STATE OF CALIFORNIA

MANAGED HEALTH CARE IMPROVEMENT TASK FORCE

STUDY SESSION

9:30 A.M.

Saturday, July 26, 1997

California Chamber of Commerce Building

1201 K Street

12th Floor, California Room

Sacramento, California 95814

REPORTED BY:
Serena Wong
CSR No. 10250, RPR
Our File No. 38034

APPEARANCES:

Dr. Alain Enthoven, Chairman

Dr. Philip Romero, Executive Director

Alice Singh, Deputy Director

Hattie Skubik

Bernard Alpert, M.D.
Rebecca L. Bowne
Donna H. Conom, M.D.
Barbara L. Decker
Harry Christie
Honorable Martin Gallegos
Bradley Gilbert, M.D.
Diane Griffiths
William Hauck
Mark Hiepler
Michael Karpf, M.D.
Clark E. Kerr
J.D. Northway, M.D.
Maryann O'Sullivan
John A. Ramey
Anthony Rodgers
Dr. Helen Rodriguez-Trias
Ellen B. Severoni
Bruce W. Spurlock M.D.
Ronald A. Williams
Allan S. Zaremberg
Steven R. Zatkin
Kim Belshe'
Marjorie Berte

I N D E X

SACRAMENTO, CALIFORNIA; SATURDAY, JULY 26, 1997

9:30 A.M.

CHAIRMAN ENTHOVEN: Good morning. Meeting is ready to begin. I'd like all the members to take their seats. I'd like particularly to thank you all for coming this morning. The task force members I think are showing a lot of commitment and dedication, and I appreciate the sacrifice of your time. In this case, sacrifice of a weekend. Also, as I look at Bill and Brad over there, I'm thinking that I regret that I didn't in advance put out an agenda and declare that this be a casual day so that I wouldn't have to be --

MR. HAUCK: I knew that was your intent.

CHAIRMAN ENTHOVEN: And I apologize for the error of not doing that. But I thank for setting the appropriate fashion trend. I'd like to ask Jill, the task force secretary to call the role.

MS. MCLAUGHLIN: Please signify your attendance by stating "present." Alpert, Armstead, Bowne.

MS. BOWNE: Here.

MS. MCLAUGHLIN: Conom, Decker, Enthoven.

CHAIRMAN ENTHOVEN: Here.

MS. MCLAUGHLIN: Farber, Finberg --

MR. CHRISTIE: Present. The alternate.

MS. MCLAUGHLIN: Thank you. Gilbert.

DR. GILBERT: Here.

MS. MCLAUGHLIN: Griffiths, Hartshorn, Hauck.

MR. HAUCK: Here.

MS. MCLAUGHLIN: Hiepler, Karpf.

MR. KARPF: Here.

MS. MCLAUGHLIN: Lee, Murrell, Northway.

DR. NORTHWAY: Here.

MS. MCLAUGHLIN: O'Sullivan.

MS. O'SULLIVAN: Here.

MS. MCLAUGHLIN: Perez, Ramey, Rodgers.

MR. RODGER: Here.

MS. MCLAUGHLIN: Rodriguez-Triaz.

MS. RODRIGUEZ-TRIAZ: Here.

MS. MCLAUGHLIN: Severoni.

MS. SEVERONI: Here.

MS. MCLAUGHLIN: Spurlock, Tirapelle, Williams.

MR. WILLIAMS: Here.

MS. MCLAUGHLIN: Zaremberg, Zatkin. Thank you.

CHAIRMAN ENTHOVEN: Thank you very much Jill.

Our goal in holding those study sessions in general are to provide background information for task force members. Early on, the content of the meetings had more presentations by non-members. But what we're planning forseeing is a gradual trend to where the work of the members in their expert resource groups and in the particular work they've been doing to study our problems will take more of the time in the study sessions, then we

will gradually be phasing down the presentations from outsiders.

So we're partway into this process now, but there is a lot of valuable background information that we can absorb by the presentations that we are going to be seeing.

The plan scheduled for today will be to entertain the first topic of discussion with efforts to continuously improve the quality of care and to manage the process of competition from the purchasers' point of view from now until 11:00 o'clock.

And then without objection, we'll move into the first report of the first expert resource group about 11:15 to 11:35. And then to the second oral report from 11:40 to 12:00. And then we'll move to a presentation on managed care's impact on women from 12:10 to 12:40. And then to a 15-minute presentation on the task force public survey, which we are planning before we adjourn at 1 o'clock.

Phil, do you want to talk about the administrative issues?

MR. ROMERO: Couple of quick administrative issues, and then one quick policy-oriented issue.

First, in the administrative area, I have some good news and some no news. The good news is you'll recall that at the time this task force was first convened and your appointment, there was uncertainty about whether task force members would be subject to the Political

Reform Act, in particular, a need to disclose assets and conflicts of interest and things like that.

We asked for a written opinion from the Fair Political Practices Commission, which just came in on Thursday. There's a copy in the mail to you as part of our packet to you, and their opinion is that it will -- it is not going to be necessary for you to fill out those forms. So we can thank the Fair Political Practices Commission for saving you all several hours of work and record keeping.

Second, in the no news department, at the last task force meeting in South San Francisco, we were asked about the status of the bill, I believe it's a Richter Bill AB227, if I recall correctly. It's a bill that would authorize the reimbursement of task force members for expenses. That bill is one of the trailer bills as part of the state budget. Its fate is therefore bound up with all the other elements of the state budget about which there's a very substantial betting pool going on in Sacramento. So there's no news there.

And the final point, administrative point, the -- I guess a bit of explanation. I am inundating you with paper. I know it. I empathize. But I really don't have a lot of choice. When members of the public request that a particular submission be provided to all task force members, I don't feel, and I believe -- and I believe a legal interpretation would confirm that I don't have the authority to selectively determine who should -- at least

for task force members -- should or should not receive that material.

I am intending to direct them or give special attention to a particular ERG, if it has a particular interest. But I feel an obligation to provide everything or most everything to everybody. Now, as a Ph.D., you would expect me to think that everybody spends all their time reading. I recognize that this is a non-trivial burden, and we are very happy to try to give you some commentary to suggest which items we think should be of interest to particular members. But that's a necessary condition.

The final point, on more of a policy point, we have distributed a document, looks like this, the title is called: "A Spectrum of Policy Approaches" and a companion, which is a matrix. In the ensuing couple months, each ERG will be providing an oral and then later a written report. Those reports as the guidelines document are supposed to provide a menu of options of potential task force recommendations in the area of that particular expert resource group.

That's important because one of the deficiencies of Blue Ribbon commissions is they often -- they often will stipulate, decide something is desirable, somebody should do it somewhere, somehow, without being very concrete and specific about the mechanism by which it should be done.

Those which avoid that flaw often fall into

either the liberal trap or the conservative trap. The liberal trap is, if it's desirable, it should be required. The conservative trap is, if it's desirable, the free market must be doing it already.

Precisely to stretch our imaginations, including my own, I basically just from memory without a scholarship produced this spectrum. It's a simple attempt to try to arrange a -- an array of alternative mechanisms that could be used if the task force decided that government action was necessary in a particular area.

At one end, the top end, it's very voluntary and not at all coercive, what I call job owning. At the other end, it's extremely coercive, legal requirements with a range in between.

The matrix is an illustration simply of a format that the ERGs can consider using. When you come up with a menu of alternative approaches as the columns do in this matrix, which deals with consumer choice -- and I thank Skubik for having produced this matrix -- you can consider for each of those columns a range of different mechanisms which are along those rows.

The purpose for this is just to provide some discipline, some comprehensiveness as the ERGs prepare their recommendations so that they're assured that they consider not only options that conform to their particular political philosophy, but also a range of others as well. This is a work in progress right now.

Just my first personal thoughts, if you find

this useful and would like it to be refined more, I can do so based on your comments later. That's all I have.

CHAIRMAN ENTHOVEN: Thank you very much. Now we're going to move into a session on efforts to continuously improve the quality of health care. We've been hearing a lot complaints and a lot of explanations of the problems in the system of competing managed care plans. And some people are probably wondering, "Well, how is it supposed to work? Does it ever work?"

We have the good fortune this morning of hearing a presentation from Mrs. Margaret Stanley, who is the assistant executive officer for Health Benefit Services for CalPERS, California Public Employees Retirement System, who are running what is probably in most respects the best model of how this is supposed to work.

CalPERS is a very important living example of well-managed competition from a number of points of view, one of which I'd like to call to the task force's attention. And that is, one of the ideas in this whole concept that was very important was that people would have a range of choices, and then as time went by, these would be responsible choices, and they would gradually migrate to the kinds of health plans that they saw best served them. And then everyone who would be in a health plan would be there to volunteer because it has its own resources.

I think one of the areas that things had

gone wrong in the recent years is that many employers have dropped the fee-for-service plan or whatever and moved their employees right into an HMO.

Yesterday, I was at Cal Western Occidential, and today I'm HMO ARB. And so it lacked that important element of choice and volunteerisms.

From CalPERS, we're going to hear a description of a successful system. And one of the keys is that the members have had a wide range of choices and has gradually migrated, not entirely, but mostly to HMOs and either to HMOs or preferred provider insurance arrangements. So we'll begin with Margaret Stanley. Thank you very much for coming. I'm looking forward to hearing what you have to say.

MS. STANLEY: Good morning Mr. Chairman and members of the task force. I am delighted to be with you this morning. And I am following your deliberations with interest.

The CalPERS Health Benefits Program is governed by the Public Employees Medical and Hospital Care Act, which is called PEMHCA. The program has proven to be successful. Employees' satisfaction scores with their health plans are rising while health care costs remain stable.

From 1993 to 1995, overall satisfaction with CalPERS HMOs rose from 75 percent to 80 percent. And from PPOs, they rose from 69 percent to 82 percent. CalPERS premium rates for HMOs were on a declining trend from 1993

to 1997. The 1998 premium rates will rise only slightly by 2.8 percent for HMOs and 5.3 percent for PPOs compared to expected premium rate increases nationally of up to 10 percent.

The CalPERS Health Benefits Program provides health coverage to over one million individuals and their families. The program provides health coverage to employees of the state of California, over 1,100 public agencies who contract with us voluntarily, and the California State University System and their dependents. The state comprises 65 percent of the membership, and the public agencies and the university system comprise 35 percent of the membership. Retired members comprise 20 percent of the membership. Public agencies regardless of their size or the risk of the population can join the program.

For example, the Mosquito Abatement District of Antelope Valley which has two employees is a member agency. New employees of member agencies and employees of new agencies joining the program who are eligible for health coverage do not have to endure waiting periods to receive benefits and cannot be denied coverage due to pre-existing conditions.

Public agency membership continues to grow for two basic reasons. First, the program offers access to comprehensive quality health care at affordable rates. And second, the public agencies save on their administrative costs. The Health Benefits Program annual

health care premiums total 1.5 billion dollars. CalPERS administers the Health Benefits Program including eligibility and enrollment for one half of one percent of the premium rate.

The low overhead is due to the economy's upscale and efficient program management possible with a program of this size. The Health Benefits Program is now all managed care.

In the 1970s, the program offered unmanaged indemnity insurance, but membership declined due to its high cost. Today, 80 percent of the membership is enrolled in HMOs and 20 percent in PPOs. This has occurred as a result of member choice for lower cost managed health care options.

As I mentioned before, 80 percent of the HMO members are satisfied with their HMOs. So the consumers in general are happy with their HMOs, and our participating employers are very happy with the cost control HMOs supply. We believe HMOs are just about the only politically acceptable and effective approach to controlling health costs.

There are four key elements to the program's success. First, choice of plans and plan types. CalPERS presently contracts with 14 HMOs, two self-funded PPOs, and four associating plans. Also, CalPERS has contracts with out-of-state health plans and has expanded existing HMO contracts to provide lower cost health coverage for members residing in rural areas and out of state. The

wide variety of health plan choices provides market competition among the health plans.

Second, active purchasing management. CalPERS requires health plans to report quality and performance measurements and utilization trends. CalPERS takes a tough negotiation stance with health plans which takes into account quality and performance measures, utilization trends, and customer satisfaction levels in addition to cost.

In 1992, CalPERS froze enrollment into one health plan due to the plan's unwillingness to reduce their premiums. CalPERS is also closely monitoring the patient-provider relationship to make sure our members receive continuity of care. We are concerned with provider network disruptions.

Third, the composition and leadership of the CalPERS board. CalPERS is administered by the decision-making board which governs the health benefits program, the retirement system, and the associated investment portfolio.

The 13-member board represents all constituencies, active and retired and state and public agency members, the consumers, state and public agency employers, the governor, state treasurer, state controller, and the legislature and the insurance industry. CalPERS is the second largest employer purchaser of health care in the nation. Only the Federal Employees Program is larger.

Due to its large size, the CalPERS Health Benefits program has been able to develop strong leadership in purchasing and providing health care. The Board of Administration insists on affordable premiums, high-quality care, and good customer service from its contracting health plan.

The fourth is access to comprehensive quality and affordable health benefits. The CalPERS HMOs are required to offer a standard comprehensive benefits package with standard co-payments. Standardizing the benefits helps the members and CalPERS Health Benefits Program administrators focus on the delivery of health services and compare access quality of care and customer service, as well as the cost of the services.

The standard benefit package also helps reduce adverse selection among health plans. Due to the fixed employer contribution for active state members, which has been frozen since the 1991, 1992 contract year, members who choose the higher cost health plans must share in the premium costs.

The number of health plans offered by CalPERS has declined over the last decade. This has been due primarily to mergers and consolidations. CalPERS has no quarrel with HMO mergers and consolidations as long as the new bigger health plans don't attempt to circle the wagons to increase premiums. HMOs will continue to consolidate. Next year 80 percent of CalPERS's population will be enrolled in just three HMOs. Kaiser, Health Net,

and Pacific Care.

If they and our other HMOs continue to improve and provide good quality, patient-focused care, and continue to control premium costs, they will have a bright future. If not, we may see more direct contracting between purchasers and doctors and hospital.

We at CalPERS believe that the health plan should be held accountable for their performance, create accountability for health care quality. CalPERS is actively involved in the California Cooperative HEDIS recording initiative called CCHRI. CCHRI was organized to collect data on HEDIS quality of care indicators for California health plans.

We have also collaborated with Pacific Business Group on Health on a number of customer satisfaction surveys. As I mentioned earlier, satisfaction scores have risen over the last three years for both our contracting HMOs and PPOs.

Last year we analyzed responses of those members who report they are high utilizers of health care services. And these were the members who reported they had been hospitalized in the last year, and those who expect to have more than five doctor visits in the next year.

We found that about half the health plans experienced a drop in their satisfaction scores of five percent or more for these members. The others experienced an increase in satisfaction or remained the same. We

shall continue to study the satisfaction levels of those members who need health care most. We believe that consumer education and public relations can go a long way to encourage improvements by the plans.

In 1995, we began publishing a health plan quality and performance report that is distributed to our members each year prior to the open enrollment period. Plan performance on the HEDIS quality of care measures, satisfaction survey results, and open enrollment exit survey results are included in the report.

Two-thirds of those members who changed plans in 1995 reported that they used the report in choosing their new health plan, but only four percent of our members changed plans each year, which we believe is another indication of high satisfaction.

I have brought copies of the health plan -- excuse me -- of the health plan quality and performance report with me today, as well as a report we published last year called CalPERS in the Health Care Marketplace.

As we delve deeper into addressing the issue of quality, it has become obvious that our efforts convey that not only to all of one million members, but the California population at large. CalPERS is teaming up with health plans to improve the health care that our members receive.

We are currently working with Health Net to implement a cardiovascular disease program to identify people who are at risk for cardiovascular disease and then

to offer these patients assistance in lowering their risks.

We are about to start a program for asthma in our self-funded plans. We are also working on the Consumer Health Access Project with Health Net. This is a collaborative effort which includes California Health Decisions, the Medical Quality Commission, and several medical groups to examine various ways of improving the referral and authorization process and access to specialty care. The solutions will be offered as best practice models for the industry. And we expect our HMOs will implement them for all our members -- all their members.

In addition to influencing the quality of care received by California HMO members, CalPERS, along with other purchasers, had been credited with breaking the inflationary spiral of health care costs in California. This has been beneficial to employers, employees, and tax payers in California.

California public employees, like all employees, need premium stability and even better reduction. Premiums doubled from 1987 to 1992. If they had doubled again to 1997, the extra cost would have been 1.5 billion dollars a year, over $4,000 per employee per year. Although our premiums will edge up slightly, a 2.8 increase for 1998, we will not allow the return of dramatic escalation of premiums, because there is still fat in the system, primarily because of excess capacity.

We will continue to aggressively negotiate

for high quality cost effective health care. CalPERS has always driven to achieve objectives which will result in improved service and medical care for our members.

We have recently adopted a leadership strategy that promotes patient-focused care as our over arching theme. This entails treating the whole patient with emphasis on prevention, implementing disease management programs, requiring our health plans to put the needs of the patient before those of their shareholders, and encouraging healthy communities.

Our future activities will focus on the following five areas. First, maintaining and increasing access. This can be done by reducing provider and network instability, assuring rural HMO coverage, and offering a choice of plans, which include one or more open-provider choice plans, like our self-funded PPO products.

Second, defining accountability. We will require plans to define accountability more clearly for what the health plans are accountable for and what the provider responsibilities are. We are in the process of establishing a list of rights and responsibilities, which will be directed toward assuring good coordinated patient-focused care.

Third, holding health plans accountable. Future quality reports may include results of performance measures that have been incorporated in the health plan contracts. For example, ID card issuance, distribution of evidence of coverage booklets, average speed to answer

telephone by a live voice, et cetera. And a grade which would be determined by looking at their performance in a number of areas as well as whether they are NCQA accredited.

Fourth, encouraging plans to invest in information systems infrastructure. This will mean that the health care industry will need to agree to standardized data formats and reporting requirements. And unless -- we will never really make progress in our efforts to improve quality of care unless we improve our data that we collect from health plans.

Fifth, we are considering risk adjustment. We are currently reviewing the feasibility of risk adjusted premiums for our program, and we have a group of health plan representatives and stakeholders advising us. We are asking our HMOs to be accountable for good quality care and hassle-free service at a price we, both the employers and the employees, can afford.

It's a challenge full of contradictions and dilemmas. We need to do this for everyone in the country regardless of their source of payment, because ultimately we are all in this together. It's as if we have a river which overflows its banks and floods every spring, which is very apropos for Sacramento. We can't go out and sandbag just our own piece of river front and expect to stay dry. We would be pleased to be of assistance to this Commission, this task force in any way we can. Thank you.

CHAIRMAN ENTHOVEN: Thank you very much,

Margaret.

MS. STANLEY: I'd be happy to answer any questions.

CHAIRMAN ENTHOVEN: Yes.

MR. HAUCK: You talked about there being still some fat in the system in the form of excess capacity. Could you say some more about that.

MS. STANLEY: Yes. Actually, I think the excess capacity is in extra hospital beds and in the number and distribution of physicians. There's an oversupply of specialists in the country, quite a dramatic oversupply in California, and there have been two few primary care physicians. That situation is improving. Of course, all of us are paying for the debt on the hospital beds which are unoccupied. So we need to try to remove as much of the excess capacity as possible.

There are other areas where there's fat in the system. One is just in the way care is organized and delivered and continuous quality improvement efforts by doctors and hospitals and other members of the professional health care team will work on that given the proper incentives. And the other area I would suggest is administrative costs; that we need to streamline administration and devote as much of the health care premium as possible to health care.

MR. HAUCK: One more. Can you -- going to rates, you referred to the 2.8 increase that you expect. What do you see beyond 1998 in terms of increased rates?

MS. STANLEY: Well, I really can't speculate on what the increased rates will be. For one thing, we wouldn't want to signal the industry in terms of what we're thinking we might be willing to accept. But I have several concerns.

One is the increasing cost of prescription drugs which is affecting everyone nationwide. And our average increase this last year was 13 percent, and in one of our self-funded plans it was 20 percent per member per year. And this is a problem we've had in the past. It moderated for a while, but now it's on the upswing again, in large part due to manufacturers advertising directly to consumers and newspaper, magazines, and television, and so on, which is creating a lot of demand.

Another area for concern is the change that's going on in Medicare. When Congress finally passes a budget, I think we are going to see doctor, hospital, and HMO cuts which will result in a pinch for those providers and health plans. And the natural reaction on their part will be to try to find somebody else to pass those costs on to. So I think we're going to see increased attempts at cost shifting.

We're also understanding that the physician groups in California are pushing back on the health plans; that they've had several years of reductions, and they're getting a lot more aggressive at trying to get some increased revenue.

MR. HAUCK: Do you see --

CHAIRMAN ENTHOVEN: Yes.

MR. HAUCK: For a person like me who, you know, is not an expert in any of this, the more -- it almost seems like we are going in opposite directions with respect to objectives here. One objective is increased quality of care, the other objective is holding rates where they are or even reducing it.

Where is that going to -- where do we get to the point where it's no longer possible to do that?

MS. STANLEY: Well, I think that cost control and improving quality are not contradictory. In fact, they can be complementary. But I think we have to be vigilant about monitoring the health plans and its providers, which means that we need good data on quality, which is our biggest struggle, which is in the beginning stages of that.

I think we have to be worried that one of the reactions by the providers to increasing pressure on cost will be to cut corners on quality, and that's the last thing we want, which is why we need to be able to monitor that. But there is still a long way to go in improving quality without cutting corners.

I would say that we don't have the exact ultimate answer on that; that we learn as we move along, and we try -- and we try to readjust as we go. I think it's particularly important for purchasers to work together. We're very committed to our association with the Pacific Business Group on Health. We also collaborate

with the California HIPC and with a Medi-Cal program. We try to talk about what efforts we can do together which will benefit the citizens of California in improved health care.

So I don't thinking anybody really knows the answer to your question. We're just going to move along and learn as we go.

MR. HAUCK: Do you see a day when you might set -- do you see a day when you -- in the PERS system where an employee who's covered would be -- would have a basic -- would have basic coverage purchased for them by the state or by the issued system, and then give the employee the ability to purchase additional coverage or quality or however you want to put that out of his or her own pocket?

MS. STANLEY: Well, actually, that's the situation now. They have a choice of health plans. Many of them have a fixed employer contribution at a certain level, and then they make their choices. If they have a perception that certain health plans offer more choice, more quality, better access, or have their doctor when the other plans don't, they can choose to pay more out-of-pocket for their premiums to chose that health plan, which many of our members do.

We have self-funded preferred provider plans, called PERS Care, which is significantly more expensive than the other plans, and many of our members choose to go into that plan and pay the extra dollars.

In terms of having supplemental policies, I would not see that as a likely possibility because you're likely to create a lot of adverse selections for those people who need the service that you're offering in that supplemental plan, and most would chose it, and then the cost would spiral out of control for that particular product.

For example, if you have a mental health rider which offered very extensive coverage in mental health, you might have just the people who think they're going to need those services opting for it. And then it would end up being very expensive.

CHAIRMAN ENTHOVEN: Clark.

MR. KERR: You mentioned that overall satisfaction has been up about five percent or so in the last three or four years. But you also said something interesting that in the last year, the people who were sick are those who had five or more visits or were hospitalized, and about half the client satisfaction went down or neutral.

And I was curious, what's going on here? Does it make a difference? If you're not sick, things are going okay. And if you are sick, things are more questionable?

MS. STANLEY: Well, I think half went down and half stayed the same or went up. The reason we did this particular analysis in our consumer satisfaction data was because it was a particular interest of mine how well

managed care plans are doing at taking care of the people who need services the most. Most people are relatively healthy. So when you get an 80 percent satisfaction level, you don't know how many of those people are using services. And I think we need to look into how well the health plans are taking care of the sickest people.

So I plan to pursue this area of inquiry, and I think our efforts in disease management will aid us in this regard. I wouldn't draw any conclusions from this rather gross analysis other than to say that we shouldn't feel overly reassured that the overall satisfaction rates are that high without looking into people who are seriously ill and how the system is serving them.

There's a proposed hospital survey that the Integrated Health Care System is planning to send out. And I think that that will be very helpful.

CHAIRMAN ENTHOVEN: Rebecca.

MS. BOWNE: Could I have a mic? Thank you. The thrust of my question is on structural change in the health care system, but I wanted to pull together a couple of threads in your written and oral statement and then ask you for some comments.

And I noticed in the maintaining and increasing access, it's offering a choice of plans, and I also notice your -- you know, 80 percent are HMOs; 20 percent are PPOs, and then you made the comment that 80 percent of all your membership would be enrolled in only the three largest plans, as we know are from consolidated

other plans.

MS. STANLEY: Could I correct that?

MS. BOWNE: Sure.

MS. STANLEY: It's 80 percent of our HMO members will be in those three plans.

MS. BOWNE: Okay. That's very helpful. I guess my question centers on the fact that given the industry consolidation, to what extent do you feel that is or is not hurting the choice of plans by your members? And obviously I note that only four percent even elect to change plans. And this is consistent with federal employees as well. We're about the same number on a national level. So I guess my question to you would be, do you feel that the intense industry consolidation among managed care plans in California has been good, bad, or indifferent? And then I do have a follow-up question.

MS. STANLEY: I don't think we know yet. I don't think that we're ensuing evidence that it's good, bad, or indifferent. Purchasers would like to see the result of consolidation to be lower cost, because of the economy's upscale and greater investment in information systems and quality and customer service.

What we worry about is they may try to have some sort of monopoly in certain areas where the result would be to try to increase premiums and increase their profits for the benefit of shareholders. And so we give some attention and thought internally to what kind of alternatives do we have.

One would be direct contracting with doctors and hospitals; although, there are some legal and regulatory restraints around that. We have looked into that. Another would be to have your own private label brand where you contract with an existing health plan to, say, a CalPERS specific health plan. And we will be sending a request for proposal out this fall.

And we will be bringing it to our board in August, where we're proposing that we look at point-of-service product and also an exclusive provider organization, which is like a private label HMO. And then we could work directly with that health plan on the objectives which are most important to CalPERS members.

So I think we need to have a variety of strategies, but we don't yet know what the result of these consolidations will be.

MS. BOWNE: That's very helpful. I also am curious. You mentioned about having standard benefits, standardized benefits among the plans. May I take it that CalPERS being a self-insured plan is not subject to state mandates, state-mandated benefits that the legislature puts on insured plans from employers?

MS. STANLEY: Well, private -- private employers are not subject to the state government because of ERISA.

MS. BOWNE: The self-insured.

MS. STANLEY: Right. That's correct. And CalPERS is not an ERISA plan, because we're a government

plan. But the legislature could choose to pass a law which makes CalPERS subject to it because we are a state agency.

MS. BOWNE: Do you have any concept about the incremental increase in cost that would cost you?

MS. STANLEY: Well, you hear about all kinds of different numbers about the cost of mandated benefits. And in general, purchasers are uneasy with mandated benefits, and our board has a position against mandated benefits, because they think having the flexibility is important.

But CalPERS does offer a comprehensive benefit package. So most of those benefits are the mandated ones that our board would choose to offer anyway. I think the difficulty with mandated benefits is there's very little flexibility so that you get those benefits stuck in law, and then medical care changes. And it would be more appropriate to have something else that you're stuck with something from 15 years ago.

MS. BOWNE: I would just enter here that I think there is a concern on the part of carriers, other -- particularly other than those three largest ones certainly about mandated benefits and certainly about the structural rules of the game that make it more expensive to provide health care such that it even reduces competition further.

CHAIRMAN ENTHOVEN: Thank you very much.

May I just ask the members to prioritize their questions. I'm getting a little nervous about the

time, as I always do. Pick your most important questions.

Mr. Rodgers.

MR. RODGERS: Do you feel that government and/or the purchaser should be more descriptive or prescriptive in what they require in terms managed care? For example, do you feel they should set broad-based requirements for -- what it sounds like you're saying, you're becoming more prescriptive in what you are requiring in either managed care or unsure.

Do you feel that's the direction that we need to go in?

MS. STANLEY: If I could ask you to clarify your question. You asked about government --

MR. RODGERS: Government or the purchaser.

MS. STANLEY: I think that purchasers, because they are into a buying relationship with the health plans can be as prescriptive as they want because it's a contractual relationship. And I believe that you can make a lot of progress in that purchasing relationship.

I get a little more nervous about passing laws or regulations which are extremely detailed and prescriptive in health care because of the lack of flexibility. And sometimes you end up with people playing to the lowest common denominator rather than trying to achieve the best performance, just getting by.

CHAIRMAN ENTHOVEN: Dr. Northway.

DR. NORTHWAY: Yes. I'm interested a little

bit about your dependent coverage. And I see you don't have dependent representation. I'm curious if you could tell us the percentage of the eligible dependents that are covered by the CalPERS program, in particular children. If that number is not 100 percent, could you give us some idea of what the reasons are for why dependents are not covered.

MS. STANLEY: I think in terms of the Board, there are representatives on the Board who represent the members, which will include the employees, and retirees, and their families. So I think they would say that they represent the dependents as well.

I think I would need to get back to you more specifically with the question you asked. But it is possible for employees to not cover a spouse or dependents. But if they cover any dependent at all, then they have to cover them all. And, like, the State has a contribution towards the dependent coverage. They don't cover just the employee. So I think CalPERS has, you know, very comprehensive coverage of dependents, but I don't know right off the top of my head what the percentage participation is.

Again, we have 1,100 participating public agencies who have different employer contribution approaches. And there are some rules that we have about how that contribution has to be structured, but I just don't have the exact answer.

DR. NORTHWAY: I guess what I'm saying, you

may offer the coverage, but is it affordable, and there is some disturbing evidence that the number of dependents, particularly children, are falling off the employer coverage programs. And to me that's a major problem.

MS. STANLEY: I certainly would agree. It's not evident to me that that's a problem with the CalPERS program.

CHAIRMAN ENTHOVEN: Dr. Northway, if you're a California state employee, you can have family coverage in an HMO free with no employee benefits at all. This is a case, you could lead a horse to water, but you can't make it drink.

DR. NORTHWAY: In that case, it would be 100 percent.

MS. STANLEY: That's right.

CHAIRMAN ENTHOVEN: Like I said, you can lead a horse to water --

DR. NORTHWAY: I didn't say they had to use it. I just wondered if they were covered on the program.

CHAIRMAN ENTHOVEN: Okay. Dr. Karpf.

DR. KARPF: The essential theme of your presentation seems to be standardization and an opportunity to do -- compare analyses.

Do you have any data as to whether that's effective satisfaction levels or understanding of your enrollees as to what they're entitled to and what they're not entitled to and eliminate or decrease some of the tensions about benefits?

MS. STANLEY: I can't point to a particular study. It is my strong impression that standardization of benefits is a huge help to employees and helping them make choices about their health plans. And I think putting out a quality and performance report that gives fairly simple information to help them chose plans is a great assistance.

I think one of our biggest areas of inquiry in the future is what kind of information presented in what way is most helpful to consumers in choosing health plans and, for that matter, providers. And it's a complicated area. And we feel as if we're making some progress every year, but we don't have all the answers yet.

CHAIRMAN ENTHOVEN: Ron Williams.

MR. WILLIAMS: There are several themes that are running through your presentation. One of those focuses on the accountability, the other on quality and also on foreign standards. When you talk about the future, there's a reference to encouraging plans to invest in information systems and information technology. And I think when you look at the central theme, the information systems are such an important pat of that.

Could you comment and amplify on where you see your emphasis will be in that regard?

MS. STANLEY: Yes. Last December, there was a health information summit that was held in Los Angeles. Health plans, purchasers, providers, and plans were

invited to -- and Pacific Business Group on Health list the catalyst for this meeting being called. And the purpose of the meeting was to agree on how we're going to come up with standardized data, which can then be moved electronically so that we can move forward on these initiatives to measure quality. And I was really amazed that we did walk out of that meeting with that consensus, and with some assignments for various groups to come up with standardized data.

So I think in the next couple of years, we're going to see real progress in that arena. They're not trying to come up with the ultimate information system, which usually dooms such efforts to failure. They're trying to come up with substantial progress. In terms of investment in information systems, these larger consolidated HMOs we feel should be able to do that. The bigger challenge we think is at the provider level, particularly physician groups where they tend to not have a whole lot of capitol. And it's just as important for them to have good information systems so they can evaluate their delivery of care. And Clark Kerr is a resident expert on that topic.

CHAIRMAN ENTHOVEN: Mr. Gallegos, we're very happy to have you with us.

MR. GALLEGOS: Thank you, Mr. Chairman. I'm delighted to be here. The question I had was, again along the lines of your comments with regards to holding plans accountable and dissemination of information to the

consumer. You mentioned in one of your responses what information -- we need to determine what information is most valuable for the consumer to make informed choices.

Would your feeling be that aside from performance results that you mention specifically in your statement, would you feel that informing the public with regards -- or better informing the public with regards to treatment coverages, you know, for certain conditions, you know, being able to compare the plans and what they provide for treatment with regards to specific conditions would be valuable information for the consumer?

MS. STANLEY: Yes, I think it would.

MR. GALLEGOS: Would you be supportive, then, of having these plans publish that information or make it available to consumers upon request?

MS. STANLEY: Is the question whether the treatment is covered or how they go about treating a particular disease?

MR. GALLEGOS: Both.

MS. STANLEY: I think that that information would be helpful. It's kind of a challenge to figure out when you're overwhelming people with too much detail and sophisticated information. And sometimes we think about what we think they should be interested in, which may not be the same as what they're really interested in. We then --

MR. GALLEGOS: If I wanted to be an informed consumer and look for information specific about certain

conditions and how the different plans treat them, you know, I'd want to have that information available. I don't know if you feel that that's as important for your members to know that information as well.

MS. STANLEY: I think it's terribly important. You might find some resistance from the health plans.

MR. GALLEGOS: Oh, there is resistance from the health plans. There's no doubt about that. In fact, my next question was going to be how are we going to deal with that?

MS. STANLEY: When they're very good at treating a particular disease, they don't like to advertise it, because then they'll attract all the people that have that disease, which is a real problem, because we want health plans and providers to become very expert at taking care of certain kinds of patients. The answer ultimately to that is risk adjusted premiums where they can attract those patients and get very good at taking care of them and be paid appropriately and not have financial problems.

That's also an area which has a lot of improvement needed. We're just looking at demographically adjusted premiums, and we would really need to get into much more sophisticated diagnosis adjusted premiums to do that well.

CHAIRMAN ENTHOVEN: Mark Hiepler.

MR. HIEPLER: We've heard a lot of

membership satisfaction surveys, and the concern I always have is whether you're actually talking to the sick people. And I'm wondering whether there's any controls in your system to make sure when you say 80 percent are happy with their coverage, to determine how many of those people who were surveyed had actually been sick, or are we just happening to get lucky and get all the well people. And then secondly, if you've done anything to determine the satisfaction level of your PPO enrollees as opposed to the HMO enrollees to see if, in fact, there is a difference.

MS. STANLEY: Well, as I mentioned earlier, we are very interested in the experience of the sick people in their satisfaction levels, which is why we did this extra analysis in the last year to look at what that was. And it's an area we want to look into much further. We do survey our PPO members as well as our HMOs, and it's slight -- the satisfaction level is slightly higher for the PPOs than it is for the HMOs on the average. They tend to like the freedom of choice of provider, and the complaint is the higher cost of those plans.

CHAIRMAN ENTHOVEN: Allan Zaremberg.

MR. ZAREMBERG: Maybe you've just answered my question. And I think you have a unique situation where people have a choice of putting in their own resources. And when people put in their own resources, it gives you an opportunity to find out why consumers are willing to do that, having a study as to why people are willing to commit their own resources.

Do they say they are? I notice in your survey, in your data here that most people leave those plans because of cost. Is that a major item? But have you done that? Why do people choose PPOs over HMOs and, you know, are they willing to commit their resources for a long period of time?

MS. STANLEY: We do an open enrollment exit survey, and the results are in that quality and performance report. The main reason people would leave the preferred provider plan would be because of cost.

CHAIRMAN ENTHOVEN: Steve Zatkin.

MR. ZATKIN: Yes. In terms of quality analysis, what is the relevant level of measurement? The health plan or the underlying medical group?

MS. STANLEY: I would say that both are relevant. When we have large HMOs with overlapping provider networks, I think that the data sort of washes out at the health plan level because they've got the same providers. So it's important to look at the health plan level on the quality and at the medical group level. And I think you also for certain procedures want to look at the hospital level.

So we are increasingly doing that in collaboration with the Pacific Business Group on Health. And I think there are different audiences for this type of information too. It's not all just from the consumer. Sometimes it's for the purchasers so that they can change their requirements for health plans and their

participating providers as an agent for the consumer.

CHAIRMAN ENTHOVEN: Two more, and then we're going to have to stop. Dr. Alpert.

DR. ALPERT: I apologize for being late. As I see it, if we look at CalPERS as a laboratory that has studied a million people being impacted in the managed care environment as recently invented, it would seem to me based on the employee satisfaction trends and cost trends that the task force should then make a recommendation that all Californians be put into CalPERS, and that would solve our problem.

(Laughter.)

MS. STANLEY: It won't solve my problem.

(Laughter.)

DR. NORTHWAY: It won't help the people that are sick.

DR. ALPERT: Assuming that that's an impossibility, at least at the moment, in a prioritization, what specific recommendations would you make for this task force to implement?

MS. STANLEY: Well, I think that finding ways to hold health plans accountable for quality access and service in measurable ways is the top priority. You have a more difficult challenge because you have all different kinds of employers and individuals across the state. So you can't easily just standardized benefits. That's been attempted politically and didn't go through.

I think finding ways to require good

information so that we can monitor the health care system is terribly important. But we have to be realistic about it in terms of the cost. And we have to be extremely careful about confidentiality when we do that. My inclination is to try to make the market work rather than trying to be overly regulatory. I think that you can achieve greater change faster that way. And so we need to find ways to link up together and collaborate so that we can have greater power in influencing the health care system to perform better, which is why we work with Pacific Business Group on Health and others.

DR. ALPERT: And your ability to accomplish these things you think are based on the leverage contained by having a million people cover it; is that right?

MS. STANLEY: That's correct. And also a certain amount of expertise.

CHAIRMAN ENTHOVEN: One comment about the idea of having everybody in CalPERS for health care purposes, and that is today Margaret can sit across the table from the health plan and say, if necessary, of course, we don't have to go on doing business with each other because I'm a purchaser and you're a supplier.

And, in fact, sometime those conversations lead to the conclusion that they're not going to go on doing business. But if she were the purchaser for all health care in California, then the health plans would have Fifth Amendment rights. So that's an important thing about the buyers.

DR. ALPERT: I understand the competitive parts in the leverage --

CHAIRMAN ENTHOVEN: Okay. Last one. Barbara Decker.

MS. DECKER: Hi, Margaret. I was wondering with your low cost for administration, which I admire greatly, how much of a commitment or what expectation do you have about dispute resolution? How do you expect a person that is having a problem in receiving what they perceive as inappropriate medical care, where do they go to get help, and how do you assist and/or triage that problem?

MS. STANLEY: Well, we would expect them first to try to resolve the problem with their provider or with the health plan's appeal and grievance procedure. If they've exhausted that or feel that they're not getting responded to at any point during the process, they can come to CalPERS, and we have an ombudsperson there and some employees who are dedicated to solving member service problems.

And we work directly with the health plans to try to resolve them as quickly as possible at the lowest possible level before it escalates. We have an appeals procedure through health -- through CalPERS where they can go to an administrive hearing and ultimately to a hearing before the CalPERS Board, which has the right under our contracts to ultimately decide the case.

And in the last year, we developed an

expedited approach for cases where the enrollee's life could be endangered. This would be particularly around experimental or high technology procedures. And it required all our health plans to use independent medical reviewers. An example being a medical care ombudsman program for cases such as bone marrow transplant for breast cancer to try to make sure they're resolved quickly and fairly.

MS. DECKER: So it's possible that someone might have gone through -- however many steps there might be in a medical group and health plan, and then ultimately through CalPERS and go through some more review process?

MS. STANLEY: That's correct.

CHAIRMAN ENTHOVEN: Thank you. Quick follow-up question.

MR. ROMERO: Unilabor leaders or the plan of the group are presumably primarily threatening to cancel their contract on the next renewal.

MS. STANLEY: Or to freeze enrollment.

MR. ROMERO: Sorry?

MS. STANLEY: Or to freeze enrollment.

MR. ROMERO: Okay. You do not tell them that their contracts have presumed any penalty or fines or anything like that. In other words, the remedies are prospective. You can affect their market structure in the future. You don't go --

MS. STANLEY: We can build in fines in the contracts as well and do have financial penalties like in

our self-funded contract. And we've consider them for provider network disruption. In fact, we will bill health plans when they have a termination with a big medical group in the middle of the year for our cost involved in moving those members around. So I think financial penalties are very appropriate in contracts.

MR. ROMERO: Thank you.

CHAIRMAN ENTHOVEN: Thank you very much. That was excellent. We're going to take a very short break in order to set up the visual case for the next presentation. So let's be prepared to be back on in five minutes.

(Brief recess.)

CHAIRMAN ENTHOVEN: Would the task force please come back to order.

Our next speaker presentation is going to be Dr. Antonio Legorreta, who is vice president of Quality Initiatives, Foundation Health Systems. He's going to be using view drafts projected on this screen. Some of the task force members over here might prefer to stand over there for part of it.

I first met Dr. Legorreta when he came to Stanford University. And he began by handing out reprints and other top scholarly research, what we call referee publications.

What he was going to talk about was not "puff pieces," but actually documented referee peer review scholarly research. He handed me some more of his

reprints, and we will -- on which some of what he's talking about is based. And we will be including copies of that in the follow-up packet for this meeting.

So Dr. Legorreta, thank you for coming.

MR. LEGORRETA: Thank you, Mr. Chairman. Members of the task force, I want to take about 15, 20 minutes to give you a global view of what we are doing in terms of assessing and improving quality of care. And I'm going to make reference to some specific points that we're graced with.

I just want to start by telling you that two years ago, we developed a new group under the umbrella of the HMO. We are in fact a research and development group taking a very quantitative approach to health services research. And the criteria for us, our group, to get involved in any particular project led to meet two components.

One, it has to help our members; and the second one, it has to be publishable. And I think one goes hand in hand with the other. And therefore, the data that I'm presenting to you today of the two projects have been already published, and the one in the archives was internal medicine.

Let me start by talking about the member satisfaction component. And I just want to briefly talk about this issue in terms of what we are doing because there were several questions about member satisfaction when I came here.

Healthland in California used to survey about 17,000 members to create an estimate rate of satisfaction for 1.3 million members. So we did administer a survey. First of all, the change to the survey that is standardizing the industry, instead of having our own survey, we adopted a double instrument. We surveyed with a 20, 30 percent response rate. We have about 150,000 surveys back in our shop that we can analyze and we can go to other databases.

The first step we took was to share this in addition with the medical groups. And the medical groups were very receptive to this type of information, and this was done two years ago. The second year, the following year, we shared this information with the health -- with the employers. And what we did was provide employer specific level of satisfaction with this particular health plan. And following that particular release, we provided medical group specific data in terms of the satisfaction of those employees.

So the employers know what medical group is providing the highest level of satisfaction with the particular employees. And in the fall of 1997, we have provided this information directly to the member. We are going to establish probably an 800 number, and members are going to be able to call this 800 number so they can make an informed decision when they have to select a group. Right now in selecting or changing medical groups, there isn't any resource for members to make an informed

decision.

When I came here two years ago from Philadelphia, I was selecting a medical group, and I didn't have any way of selecting one. I didn't know anyone. So I asked the medical director at Health Net, and he suggested one. And the group was cancelled two weeks later. And this is internal sources. So we moved away from that. This is actual data I'm presenting to you from Palo Alto Medical Foundation. And these are employer driven reports at the medical group level, and this is what we are doing.

The second component is involved in improving quality of care. The second thing we did in using the health plan employer data information set, we looked at the rate for annual exams, for eye exams for diabetic members was significantly low. And this rate was consistently low with other health plans throughout the nation. So what we did was send a letter to all the health plans, to all the medical groups, and say these are your HMO diabetic members, and we don't have any evidence of an eye exam.

Two weeks later, we sent a letter to all the members with the ADA guidelines regarding this particular preventive care service. Needless to say, many, many, many medical groups called me, and the calls were angry calls saying "These are not your patients. These are our patients. You have no business in doing this." And my answer was two-fold.

The first one is, well, if you are doing it, you know, the rates are not reflecting their action. And the second is, you know, you are a scientist. Why don't you wait for the data. And if it doesn't work, we won't do it again. And they agreed to do that. And we have the data here showing -- and I apologize. I'm trying to do this with my left hand.

What we have here is the data for three years worth, 1993, 1994, 1995. '93 is in white -- I'm sorry. Yellow. '94 is in white. And that salmon color is 1995. The intervention to the members took place in August of 1995. And you can see the dramatic increase in the following two or three months after that particular intervention.

Now, I'm sure that you're looking at this, "Well, you know, after three months, it goes down to where it was before." So all we have to do now is do this intervention on a quarterly basis so that we can maintain this effort in a more appropriate way.

Now, in terms of talking to the physicians instead of telling them -- sending them a very colorful graph like this one, you know, saying it really works, because as soon as they see the HMO logo, they throw everything in the garbage.

So what we did is we send them a reprint diabetes care. Diabetes care is one of the leading journals in the world in terms of diabetic care. And we published those results, and we send a letter saying, you

know, "These are your members participating in this study."

And to the extent -- as a physician, I think what we read on a monthly, weekly basis medical journals, and that's what we believe in. So they were very receptive to these. And now we have 32 medical groups mailing these letters to all the diabetics with their logo and our logo. So I think that's a way of gaining participation of medical groups, by providing credible information to them.

I think this is a very simplistic approach to improving the quality of care because we're improving the quality of a process of care measurement. I think if we need to -- if we want to move into more sophisticated analysis, we need to understand the epidemiology of our population.

And to be able to do that, what we have done in this particular group is to look at the five specific condition: Diabetes, asthma, high cholesterol, high blood pressure, and depression. And within each of these categories, we can be able to categorize based on demographics. And we are doing this because we know that, for instance, diabetes or diabetics in this particular case, under 20, the needs and wants in terms of medical and social services are going to be significantly different than diabetics over 50.

And you can see the distribution there. The green section of the pie is the population between 50 and

70. The blue pie is under 20, and the purple is 21 to 50.

And I actually -- these are actual data.

But if you look at depression, for instance, you look at depression, and really the magnitude of the problem is in the population 21 and 50. What we need to do is to classify the population to understand the population and then to have specific intervention for them.

I have to tell you that what I think we've been calling managed care for the past 15, 20 years has been really managed utilization. And if we really want to do managed care, we have to understand our populations, because it all the -- in terms of the fat in the system has been reached that way. So what we need to do is really to understand the populations that we serve, and not ask them to adopt to our system, but really to adopt our system around their needs and wants.

(Applause.)

MR. LEGORRETA: Thank you HMO representatives.

Now, let me ask you something. Many HMOs and groups have a list of 20 disease management programs, and said, you know, we have to focus on all these conditions because it looks very impressive when we talk to a group of people.

But let me just show you in terms of the consumption of health care resources of these five conditions. They account for 16.6 percent of the population in this health plans in California, but they

account for about 67 percent of the dollar cost in terms of pharmacy and account for about 50 percent of all the consumption of health care sources at the hospital level. So we don't need to impress anyone. We really need to improve the quality of care of this population in these five groups.

So what we did is to really move in disease management mode. And I think it means many different things to many different people. If you talk to the pharmaceutical people, the pharmaceutical companies, this is what management means to them is to increase the consumption of the drugs that they manufacture.

And so what we are doing here is really focusing on three major components. How do we improve the quality of care, the quality of life of our members, how do we improve the function of status, and how do we improve work site absentees. The three of them are tightly related. And what we are doing is improving disease management skills of the patients. And then I'm going to show you how we are doing this.

For asthmatics -- and I'm not focusing on one particular study. For asthmatics what we did is to administer over 30,000 surveys using SF36, the short form 36, to assess functional status of the general population, and then we administered also the type instrument, which are technology on patient experience and are specific instruments to assess the quality of life of a specific population with a chronic condition.

And the response rate for this survey was over 30 percent. So we have 9,000 of these responses. Now, this is very significant because the instruments are very lengthy. The SF36 has 36 items. And then the type instrument has about 18 items. These are the results for this particular population. Given the responses that we received, we were able to classify the patients in mild, moderate, and severe asthmatics.

Mild are in blue, moderate are in yellow, and severe are in pink. And you can see the physical and social functioning of this population decreases as the severity of disease increases. Now, this may seem obvious to you, but let me just show you some other data. If you look at the impact -- why are employers interested in this type of data?

First of all, they want to, of course, improve the quality of care and service of their employees. But if you look at the bars on the far right, you can see that they missed one or more days from work in the past month. 50 percent of the severe asthmatics missed one day from work in the prior month on a monthly basis due to the asthma-related problems.

Now, this is very important because, again, what we are trying to do is to move away some employers from thinking that the premium is the only thing that they need to concerned about in terms of the health care services that they provide to their employees. But also that if they focus on the quality of care and quality of

service, they can have a return on the investment in terms of increased productivity. So what we need to do is create a win/win situation for everyone.

Now, in terms of the disease itself, oftentimes for asthma, we just focus on the long functioning in this particular case. But if look at this data, risk of depression and emotional problems, 50 percent of the severe asthmatics have emotional problems because of asthma.

So we are just focusing on asthma, on the organic disease itself. We are really ignoring an important component of the overall individual, the individual's health. So we have to look at the individual as a whole, and that's what we have done in this particular problem.

Now, what are the needs in terms of medical needs, on med medical needs. If you look at this, the utilization of the peak-flow meter, peak-flow meter is strongly recommended for asthmatics so they can assess their own functioning on a daily basis so they can identify when -- before they have an asthma attack.

Severe asthmatic, only 28 percent have a peak-flow meter. Of the 28 percent, only 19 percent use it on a daily basis. So here we have an item that is strongly recommended under international guidelines for asthmatics. And our asthmatics don't have it or don't use it. So that's the first thing.

The second issue is knowledge about their

disease. And we have one question here. It's very important for us. It's still smoking cigarettes. And you can see that the severe asthmatics, 20 percent of the severe asthmatics smoke. And the average cigarettes per day are 16.5 cigarettes per day.

Now, I have seen very sophisticated disease management programs where you have nurse's counseling and, you know, very aggressive drug management. But here we have two very basic components that if we don't fix, asthmatics are not going to get any better.

One is they don't have their peak-flow meter. And the other thing is if you don't ask them to stop smoking and we don't provide the tools for them to stop smoking, nothing else is going to work.

Now, this is descriptive data. Now, we have a lenient regression model on several -- actually, I'm just going to present one to you where we -- since we have demographics on race and ethnicity of the population, and we have other information, we can predict what are the strongest predictors of someone having or not having in this particular case a peak-flow meter.

Let me just try to explain this. If you look at the race and ethnicity, we have the white population as the reference group, and one -- these are odds ratio for those with -- had physical background. And one would be, like, the average of the population. So we are comparing against the reference group. So you can see, the African-American population has 0.8. So it's

lower than the reference group, but it's not statistically significant.

Also, this is very important for us if we want to tailor a disease management program, because we need to know who our members are in terms of their racial and ethnic background. What is really very important for us, and I want to mention to you, is the use of the specialist. And if after you control for severity, demographics, and everything else, the likelihood of asthmatics to have a peak-flow meter is three times as high as compared to a generalist, if this asthmatic has been treated by a generalist.

Now, what we have here, this is a very scientific way of approaching the issue of access. The point that I try to argue to the policy makers within the HMO industry is that we don't have to create, we don't need to create an access program that includes everyone just for the sake of political and social pressures.

What we need to understand is what is the access program that will better serve our members. And in this particular case, if we can identify a segment of the population that is going to be better off being treated by a specialist, we should provide access to those particular population, because we know that is going to be better for the quality of life, functional status.

Not only that, but in terms of the consumption of health resources, even from the economic perspective, it makes sense. This is really a win/win

situation for everyone. But I think as an industry, we have to invest in this type of instruments and analysis to be able to focus here. I'm sorry. I'm running over the time.

The intervention program that we have right now for the asthmatics, we have a case control randomized study, again, because now that we identify the needs and wants, we also need to identify what is the best way to solve those issues of those problems. So with the partnership of over 22 medical groups that are working with us, we randomize all these asthmatics. And we have different interventions where we are sending the peak-flow meter and the very interactive material to asthmatics directly from us.

Another group is getting it through the medical group. And another group is not getting anything. It's the control group. Because we also want to know what is the affect of this particular intervention. And what we are finding is that the medical group cohort is requesting the peak-flow meter significantly less often than those that are receiving the peak-flow meter directly from the health plan.

This makes sense, because we are facilitating the process by providing these tools to the medical group. We are asking them to -- we are asking them to pass a hurdle. They have to make an appointment, drive, pick it up, come back. If they get it at home, it facilitates that process. And that's where the health

plans can play a very important and very crucial role in modifying and improving the quality of life of our members.

Now, the last piece that I want to talk about is -- I'm sure that everyone is familiar with the HEDIS criteria. the Health Plan Employer Data Information Set rates. And these are the measurements. And although I think these rates are very important and these measurements are very important, if we assume that because a health plan has high mammography rate, the members are receiving high quality of care I think is misleading.

What we need to look into is not only the process of care measurement, but also on the quality of the pap smear or on the quality of the mammogram, because it will be misleading and detrimental to the health of our members if everyone has a pap smear, but the quality of the pap smear is very poor, for one thing. So we are looking at the technical component of the pap smear.

The other issue, what is a cognitive component of the pap smear in a way that if we have very good quality pap smears, but we have a site of pathologists reading 300 pap smears per day, the quality of the reading is going to go down.

I'm not diminishing the role of these measurements. What I'm saying is that this is really the entry before any health is meant to be in the medical delivery system. We need to go beyond those measurements and do more if we really want to improve the quality of

care of our members.

The point -- I'm using this graph just to make the point in terms of the issue of quality and cost. I'm a strong believer that if we focus on quality, we are going to use resources in a more efficient way. We don't focus on cost. We focus on quality. In this particular case, we published this paper.

And, in fact, I think they're going to distribute to you the paper today. We published the result. We followed a cohort of 280 patients over a period of four years, adjust them by clinical stage for breast cancer. And what we found is that significantly patients in stages 3 and 4 are significantly more extensive, consume significantly more resources than patients at stages 0 and 1. So really by increasing the mammography rate and downstaging the disease, we are going to be able to not only improve the quality of life by increasing survival rate, but also consumption of health resources are going to go down.

Now, what are we doing in that end, in addition to the mammography rate that we are focusing, these are actual data for our health plan in California, is that we developed an algorithm to identify newly identified patients with breast cancer on an annual basis. And we identified these patients in California.

We pulled the medical records for all these patients, outpatient and inpatient, and then we have Dr. Robert Parker, he's internationally known for breast

cancer and prostate cancer, and someone from Philadelphia had asked me to come and talk to him, and he's -- I feel like he was ready to retire and everything, and I went to talk to see if he wanted to recommend someone to do this work on his behalf. And he said what's wrong with me.

So he did the medical record review for us. And this is the number of patients with breast cancer by age brackets. And I just wanted you to focus on the number of patients under 39, patients 40 to 49, because the guidelines are so -- almost a month ago, two months ago in terms of screening for breast cancer, three were focusing on patients 50 and over. But we have a significant cohort of members that are under 50 that are going to develop breast cancer.

Now, what we're doing is identifying, first of all, what was the distribution of these patients. And the other thing that we have also, what is the clinical stage of these patients? And what is the breakdown? And again, these are not made up data. These are actual data that we have, the stages 0 to 4, 0 being the more localized type of disease, four being the most spread type of disease, and you can see the distribution.

And what we need to provide, not to our employers, but really to our members is that by increasing the mammography rate and I show you that increasing the mammography rate is important, but also to show you that we can shift the staging of disease to the left, downstage disease. And the only way to do that is if we focus on

this particular analysis. If we just focus on the mammography rate, I think I'm just giving you not even half of the story. Just probably like 20 percent of the story.

So we need to link these measurements, and that's what we're doing. And this assessment is now an annual assessment for this particular HMO so that we can link then the clinical stage with the mammography rate. But also to the extent that we have all the medical records, the full medical record, we can identify what are the treatment patterns for these patients and identify what medical centers have the best outcomes and treatment patterns according to guidelines compared to others. And we're going to be sharing this information.

Now, I don't think this information is proprietary. I think we published all this information in peer review journals, and I think that this eventually will spill over to the general population in another form. Thank you.

CHAIRMAN ENTHOVEN: Thank you very much, Dr. Legorreta. We'll just be able to take a few question.

Steve.

MR. ZATKIN: One of the public policy issues of interest is how physician incentive arrangements either encourage the kind of behavior, positive behavior, clinical behavior that you're talking about or discourage it. Could you identify those?

UNIDENTIFIED SPEAKER: Speak into the

microphone, please.

MR. ZATKIN: I said one of the public policy issues of interest is how physician incentive arrangements either encourage the kind of positive behavior that you're talking about, clinical behavior, or discourage it. Can you identify for us those physician incentive arrangements that you think are encouraging what ought to be encouraged and those which you would argue should be discouraged?

MR. LEGORRETA: Sure. I think there are two ways to quantify physicians. The first one is the financial incentive; that if we create a performance-based contract structure where we are not focusing on utilization, but where we are focusing on quality of care, and we make a significant contribution to that fund, it's going to have a meaningful impact on the overall quality of care that our members receive. And, in fact, we are moving towards that end.

Last year, we instituted a new program for medical groups where one percent of one half is directly linked to three component: Member satisfaction, quality of -- process of care measurement and that of management. We're getting the data from the medical groups.

We also have a program as of 1/97 for hospitals. We want to move away from thinking that the best contract is the cheapest one. And what we have to do is we have developed a criteria, and we have already seven hospitals under that particular program where a significant component of the revenue is tied directly to

service issue measurements and quality of care measurements.

But I think, however, that the stronger incentive, even more so than the financial incentive, is going to be dissemination of this data to the public in general. I think that we need to empower the members and we need to -- again, this is my opinion, that we need to stop patronizing our members and the public in general thinking that they won't understand the data.

Everyone -- the majority of the people in this country own at least -- or are related to someone who owns a mutual fund, and they know how to read the wall street journals every day, but we think they are not able to understand what a percentage is. I think we should stop that component.

CHAIRMAN ENTHOVEN: Thank you.

(Applause.)

CHAIRMAN ENTHOVEN: Helen Trias.

MS. RODRIGUEZ-TRIAS: Yes. Thank you very much. I wonder if you could pursue the issues of the outcomes a little more because HEDIS is mainly process. And I think you touched upon that by a correlation between the frequency in mammography and the shifting toward earlier diagnosis. But for instance, the paps being related to actually early staging diagnosis, the prevention of cervical cancer, because that is a preventable disease in some such outcomes.

MR. LEGORRETA: Yeah. I think with the pap

smear, specifically, I think the issue there is what is the appropriate follow-up after we identify the negative or positive pap smear through the lab data. And what we are doing, right now we are developing this program -- I mean, when I was in the northeast, we implemented this program. We are in the process of designing it right now in California. We are doing a random selection of pap smears from the lab, and we are sending these to a national expert to give us two opinions.

The first one is what is the technical quality of the pap smear. And the second one, what is the quality of the reading of that particular pap smear. Now, by increasing the data submission from medical groups, in general, once we identify a positive pap smear through the system, what is the appropriate follow-up, and that can be identified through the claims data as well. And I think it has significant amount of outcome studies that we're doing. But given the limitations in terms of time, you know, I'd be happy to give more detail, but I don't know, Mr. Chairman, if I have the time or not.

MS. RODRIGUEZ-TRIAS: My question wasn't so much as to the special study, because they've always been conducted. But as to weeding -- some outcome indicators into the database that we are getting in general.

MR. LEGORRETA: Sure. I think the outcome -- specifically for breast cancer, I think the outcome -- the final outcome should not be what is the mammography rate, but is really what is the staging of the disease at

the health plan level. I think we should invest on that.

Now, there are many registers that collect that type of data, but the timeliness of it is laughable. Why do I care if the staging of disease is such five years ago. I mean, I can't do anything if the data is five or six years old. So I think it's upon us to be able to improve upon those other elements.

CHAIRMAN ENTHOVEN: Bruce Spurlock.

DR. SPURLOCK: Thank you, Dr. Legorreta, for your presentation. I'm going to go back a little bit to disease management that you talked about. And its interesting that with most disease management, I understand, and as have you presented it, it involves a lot of non-physician source of medical evidence including education and smoking cessation and those types of things.

I'm wondering if greater patient responsibility and greater self-caring involvement in the process of disease management would be a quality improvement? What do you think the barriers are to expanding disease management to other diseases, other areas? And in particular, with a medical model we have set up with acute care and intervention by people who are licensed in those nontraditional areas, what are the barriers that you see to expanding such activities?

DR. ALPERT: I think one of the many barriers is the culture under which we are operating right now where assume that the member, the patient, is really a passive member of this very active environment. I think

that -- I have to tell you that -- you probably are familiar with all the guidelines, clinical guidelines that have been developed. We have thousands of them.

And what we need to develop next is not another clinical guideline, but develop a guideline to disseminate guidelines. We don't have a way to disseminate the guidelines, first of all. And the second issue is I think the guidelines should be disseminated to the members as well, because they are the ones that have most at stake.

If they have breast cancer or asthma or diabetes, and if we empower them with education, they're going to change physician behavior sooner than we, meaning the industry, are going to do it. I think that's one of the biggest barriers, the cultural issue. I think to the extent that we are able to provide, you know, evidence-based results in terms of the implementation of the process, I think it's in the horizon. I think it's going to happen.

CHAIRMAN ENTHOVEN: Great. Thank you very much. That was very interesting. Excellent demonstration.

MR. LEGORRETA: Thank you.

(Applause.)

CHAIRMAN ENTHOVEN: We'll next go to our expert resource group on new quality information with Clark Kerr and Rodney Armstead.

MR. KERR: I wanted to let you know that

this material is very fresh. Rodney, who wanted to be here, was unable to be here due to a conflict. But he and I were working on this on the phone between 5:00 and 6:00 yesterday evening. And I'm not sure if it's because of the late hour on Friday evening or because the presentation is Saturday morning, but we decided to be a little bold and a bit specific. So you can blame it on the late hour.

We realize that this issue of quality improvement is a very complex issue. It's a very important issue. We struggled a long time to try and think of how we could be a little bit different than what everybody else studying this issue suggests. What we'd like to do is make several specific recommendations. They are preliminary thoughts. They are really raised to sort of get the reaction of the task force and see what you think.

First of all, we defined five audiences for health information in the state of California. First, of course, consumers. Consumers need quality information to be able to choose the providers and health plans and the treatments that are most appropriate for them. So they are the primary goal.

But also very important, health information can assist the actual health providers in improving quality of care to find out what really works, when, and why, and under what circumstances.

Third, we think that the information is

important to purchasers, like CalPERS and others, both public and private, to be able to help them better determine who's providing the best value.

Fourth, it's important to have this information to enhance both health professionals and research efforts to improve evidence based medicine. And as we all know, only about 25 percent of medicine at this point is evidence-based. As a frequent flyer on airplanes, I'd like you to think how it would feel if about 25 percent of flying was evidence-based and 75 percent were not.

Finally, it's important that policy makers have this information in order to better state priority of health in the public and to help make decisions.

It is our feeling, and everybody's feeling so far expressed, that the current information, although going in the right direction, is really inadequate at this point for all parties to do all of these jobs. We have some loaded studies, some good studies, but limited studies. Many of them are time dated, lots of anecdotes.

Essentially, we're at a situation now where you can pretty much do what you want. You can conclude that managed care sucks, but it is tremendous. And we don't really have a full idea as to how it stands at this point.

I was amazed to hear that part of my talk or our talk was given by Margaret Stanley. We believe there are two things that are absolutely critical before you can

really get into good quality information. One, obviously are risk adjustors. As Margaret made a pitch, this is absolutely critical. If you're going to compare apples to apples, you have to have these risk adjustors. They're not at the stage they need to be.

She also made an excellent point that without risk adjustment, suddenly if you store the sicker patients to that type of care, you essentially bankrupt the provider unless you can give some sort of computation. So we need risk adjustors for two important reasons.

Also as Margaret pointed out, we need to get towards electronic records. The current system of using paper records and trying to make any sense out of who's doing a good job and who's not and trying to find evidence-based medicine is almost impossible and costly.

There are specific suggestions. And they're specific, they're actionable, they're provocative, we want to get your shared responses. First of all, one idea to try and advance the risk assessment area. We suggest that the state of California consider the idea of partnering either with HCFA or one of the other states that's working on risk adjustors, and these are Colorado, Missouri, Maryland, the ones that we're aware of, and for a waiver and make it a Medicaid demonstration project to use Medicaid or Medi-Cal program in this state.

We're suggesting a partnership because we don't think everybody ought to reinvent the wheel. We also think that a partnership can also help with federal

matches, not help just the state of California put up all the money but feds as well.

Second recommendation is with regard to pushing electronic records. We realize this is a difficult area. We realize that there are unsolved issues relating to doctor/patient confidentiality and privacy. We realize that they are still lack of definition -- common definition and language, which makes it difficult to compare things together. But those can be solved, need to be solved.

We are suggesting that we consider the idea of having the state establish a public private task force, somewhat similar to the managed care Task Force, maybe electronic records improvement task force for the state that would be a broad representative group like this one in terms of having consumer groups, having purchasers, government, providers, and so on.

And that this group would be charged with coming up with a state-wide strategy on electronic health records by the year 1999. So we're trying to push that issue. We also suggest that we consider the possibility of requiring that electronic records be in place in a specific period of time just to sort of force the issue. And what we're proposing is that they be phased in no later than the 2002 to 2004 years. And that the bigger organizations, such as the larger hospitals and larger medical groups have to have these in place by the year 2002, and the individual doctor offices, community clinics

, and so on would have to have them by 2004.

Another specific area is we would like the current data programs that are held by the state have hallowed by the fact, as you know, California being the only state in the union that requires the legislature and the governor sign off on every additional or subtraction of any data element that's collected.

We suggest that we need to move from a statutory approach to a regulatory approach, like the other states have. And we suggest that the legislature should be the one that sets the general guideline, but that either a state commission or, as Rodney suggested possibly, a public, private entity such as maybe the Fact Foundation for Accountability, something like that to be the actual one that decides what are the data elements that are then subtracted. And that their decisions, understanding that it costs a lot of money to add the endowments, but understanding that if it were to improve quality of care or if it were to improve consumer's choice between treatments and providers, that those be the criteria to add.

Fourth, we're suggesting that -- and this was also suggested by both our previous speakers -- that we endorse the idea that information and quality prevention be collected and disseminated, not only on the health plan level, but also the treatment level, hospital level, medical group level, ambulatory service sites and so on.

Our fifth and final recommendation has to do with recommending that a series of specific and ongoing evaluative studies be proposed and undertaken. And here are some possible examples that we came up with. These are not necessarily all-inclusive or necessarily all that have to be done. It's to get compared performance that would be available to the public, to the legislators, to the providers, and so on.

But there would be such things as, at the health plan level, looking in to see which of the health plans actually use the data available to chose hospitals, putting hospitals into their networks, for instance, that use the data that comes out of the state's study depending on who does the best job in hospitals, which hospitals do the best job in treating MIs. Does that make any difference? Did you have hospitals that do better or worse? Are any of the HMO or other health plans actually taking this information and making use of that in their network?

Another thing that would be interesting to look at is which health plans actually are receiving and evaluating members -- member either encounter or preferable encounter and outcomes data from the medical groups. It seems to us a little difficult to believe that if a health plan doesn't get some of that information, it would be hard for them to really be doing much in terms of quality of care. But it would be interesting to see who's got that information.

Ideas in terms of medical group information. One of the things that Antonio brought up, it would be interesting to see in terms of basic medical groups who does the best job in detecting cancer at stages 0, 1, 2, when it's most treatable versus those that don't do as well in stages 3 and 4.

Also, it would be interesting to find out who does the best job in improving health habits. For instance, actually getting smokers to stop smoking, getting people to start exercising. Not who talks to people about it or who measures it, but who actually gets accomplishments done.

Also, who accomplishes physiological changes that we know are important, to get people with high blood pressure to actually get them under control. Getting people with high cholesterol, get that under control. We want to see some actual results.

Same thing with chronic disease management. It would be interesting to see functional outcomes, see how the medical groups do there and how they might vary. Same thing with prenatal care and prenatal outcomes.

At the hospital level, there are a couple of things that are important. Some of these things are being started now. One is to look at issued outcomes. We're doing that in the state of California with MI's, treating heart attacks at this point. There's been a Johns Hopkins study in the state of Maryland which has looked at major gastrointestinal surgical outcomes, risk adjusted.

In the case of California and the case of Maryland, we found that there are differences as much as two and a half times to one. 250 percent differences in the risk adjusted mortality.

I think it's important this type of thing be done and be available to everybody to see. We also think that for safety reasons it's important to get some information related to Atherton disease. And specifically, we're thinking about infection rates, hospital acquired infections, surgical site infections, things likes adverse events, those types of things. Data collection, why should people know about this? It's a basic safety type of situation. Putting that type of thing in the spotlight could certainly help, an emphasis on it would help that type of thing improve.

Finally, we think it's important that all of these groups be evaluated and looked at in terms of the actual willful involvement that they get consumers involved, in terms of the action and decision making. Who does best job in educating consumers about the disease they have. Who does the best job in giving them options. Who gets them really involved, because that is one of the things that groups are particularly interested about, and most important for consumers and being able to feel satisfied with what happens. They want to know what the situation is; they want to be involved in the process.

And finally, who does a good job in respecting preferences of patients. There have been good

studies in terms of both nurses and physicians which seem to indicate that either they don't have the slightest idea of what the patient's preferences are, or they ignore them. And that is important for patients in terms of where they're coming from.

Who does a good job in these areas and who doesn't. These are things that are measurable. Some of them would come from clinical records, some of them would come from patient surveys. Those are our five basic ideas. They may be bold and provocative because of a Friday night discussion. At least we thought this would generate some discussion. And we would be interested in hearing what you have to say.

CHAIRMAN ENTHOVEN: Dr. Spurlock.

DR. SPURLOCK: Thank you. They are interesting and provocative. And actually I think they're a strong vision for the future. In your deliberations, I'd be interested -- I think a few of you discussed and have thought about perhaps for the future discussing issues that I think are really critical from a pragmatic standpoint, being able to accomplish that vision, which I is very bold and provocative.

Some of those would be identifying what the costs are, and then the feasibility. And as a physician, I'd be very interested in my patients -- I think you can tell from the way I was eluding to the question of Dr. Legorreta, that health behavior is a critical thing we need to do from the public health standpoint.

I'd be very interested as a physician in knowing that there's a tool out there to measure how much people exercise. I would love that, if you could objectively standardize something like that. I'd say that is not in existence. And the feasibility in doing something like that at the current time is not there. So if the feasibility is difficult, what steps we might take to accomplish those objectives, because I think really that's the stuff that's going to help us. If we know how to measure whether smoker who do and don't quit, you know, we have carbon monoxide measures and those kinds of things that are sort of crude, but if we have the ability to do that, I think we'll accomplish a lot. Absent clear tools or evidence of feasibility, it's hard to know what we can really accomplish in what order.

And I think once you do the cost analysis, and once you do the feasibility analysis, the priority issue sort of falls out from there. But that would be in the five things you listed in the subheadings how I think we could approach -- and I'm trying to get information and quality that is most useful early on and helpful and something we can attain in the near future.

CHAIRMAN ENTHOVEN: Dr. Karpf.

DR. KARPF: I would just amplify that. I think data costs, and I think that would be realistic in terms of what we're going to require.

UNIDENTIFIED SPEAKER: We can't hear you.

DR. KARPF: I would just amplify on what Dr.

Spurlock said. And I think from my perspective, we've got to recognize the data costs. I think if we start finding data elements we want to collect, we certainly need to define and make sure that it in fact is accessible and in fact obtainable.

I think it's easy to say we should move to electronic record. The reality is somewhat different. There is nothing that I know of that really has a well-based electronic record. My own institution is trying to invest in that. We find that investment a very substantial portion, you know, 50 to 100 million dollar range, and we're not even sure we can do it at that point in time.

I think if we come forth with recommendations, they need to be pragmatic in terms being implementable, appropriate in terms of making sure that we find a problem and limit the scope of the problem and be reasonable in terms of the cost. But someone has to decide who's going to carry the financial burden.

CHAIRMAN ENTHOVEN: Okay. Dr. Rodriguez-Trias.

DR. RODRIGUEZ-TRIAS: Yes. There's a comment to the last comment. I'm agreeing on the difficulties of that, and having been involved in even trying to get uniformity of recording in medical charts just so that we could review them adequately over the years. But there are some common databases that can be extracted if enough of the consensus is created on your

encounter or contact sheets that may have some significance. There are certain things we could track a lot better than we do if we would agree on any form of database.

CHAIRMAN ENTHOVEN: You know, I was thinking in the research literature studies done by Brook and others, just using claims and counter data, they can get things. Actually, Legorreta was talking about it, where certain basic processes performed are not -- patient comes in with some condition and certain things everybody agrees ought to happen. Either they do or they don't. Brook has done those studies on Medicare. I've been impressed by how much they could do with just a basic claims statement.

Dr. Gilbert.

It seems like this is a matter of interest to all the doctors out there.

DR. GILBERT: Just one question, one comment. The question is when you talked about risk adjustment, you mentioned in the concept two things, data, data collection, and the need to make sure that your data is looked at from a risk adjusted point of view, which makes sense. We talked in the surveys. Two is payment. So I'd like you to comment in terms of your Medi-Cal managed care proposal demonstration project.

And then, two, I'm very excited about what I heard in terms of the data issues and the collection of quality information listed to focus on the medical group level. And that is something that we talked a lot with

this task force. The majority of the activity, majority of the treatment decisions, a lot of the actual results that occur at the group level and at the physician level.

So I think all the caveats are in place in terms of whether we have the data to do that. Dr. Legorreta certainly puts some info out there. Is that theme of trying to move down a level in terms of the quality study as strong as you wanted it. And then to that question about what specifically do you mean in terms of the demonstration project?

MR. KERR: I think that one of the concerns has been -- and certainly we weren't the only ones thinking about this -- is that different medical groups and even different health plans can get different levels of sickness of people. I mean everybody likes to claim they've gotten sick. We'd like to find out who does.

We all know from they studies that have been reported and so on. If you've got a very sick population, that could cost you 200, 300, 400 percent more if you have someone with chronic diseases than the average person in the health plan.

We heard testimony, for instance, in San Diego a month and a half ago or so where one of the physicians said the comment that the sick patients has become the enemy of the physicians now because there's not this risk adjustment method.

Essentially, you're getting the same amount of money whether you get healthy or sick people. You

don't want to see sick people because they're going to bankrupt you. The other problem is if you get the information out who's doing a really good job treating people, and the sick people go in that direction, what have you done? If you've got a medical group that treats cancer and diabetes real well, you end up with all the diabetics and cancer folks, they're going to go out of business.

We also know from the Pacific Business Group on Health survey that right now the medical groups are reporting that only about 10 to 11 percent of any adjustment is made based on the risk they get. And yet that can -- you know, if you're really sick, it can be much more than that type of situation.

So what we're talking about is trying to find out a way to see who really get the sickest cases, and then pay them accordingly. If you've got a tougher situation, tougher job, you're going to get paid more.

So we try to get rid of the entire system now which is really skewed towards getting the healthy risk and not advertising the fact that you really do a good job with sick people. That's just not what we're trying to get to.

So that's sort of the basic idea behind it. There's a million problems, but it's tough to get risk adjustments down. But we need to work on it, because otherwise the system is never going to work as well as it can.

Some comments on the prior idea, I think we agree that costs have to be considered and feasibility has to be considered. And that's why we're talking about some time frames. Electronic records are not easy. That's why we're saying up to 2004. That's seven years away.

The other thing is if you look at health care industry in terms of information, we hear about all these costs on information and so on. The health care industry is putting in somewhere between one and two percent max into the information in the budget. All other service industries are putting in between 6 and 8 percent. So what's more important? Banking in airlines or health care in terms of people's lives.

So I don't know that this is a good -- and it's considered cost of business by banks and by airlines, so why is health care which is three or four times less investment complaining about the cost when they're so much farther behind the rest of society? Anyway, those are some responses. Thank you.

(Applause.)

CHAIRMAN ENTHOVEN: Did you have your hand up?

MS. O'SULLIVAN: Yeah. Couple things. Did you get a chance to talk about what kind of information was going to consumers that the doctor spoke earlier talked about that -- sort of patronizing consumers, you talk about waiting times, satisfaction surveys, but not the real sort of medical issues that people might really

care about if the information was available.

And also in terms of data collection, do you think we are thinking very differently in what way we should be thinking in terms of Medi-Cal patients and Medi-Cal focus going into managed care health?

MR. KERR: I think the idea of the patients, you know, the people who are interested in wait times and so on, is that may be what people who are not at risk are interested in. But I think you need to look at all the work that's been done by groups. That's the least of their concern. That goes way down on the list.

In fact, the whole issue of courtesy is considered very important basically by patients. They're much more interested in the idea of who gets involved in decision making. The actual emotional support as opposed to courtesy, they are different types of things. Who does the best job in explaining what it's like to go into an MRI or to have something put down your throat, what about the help when you go home, the discharge plan, so on.

Those are the critical things that people who are sick are interested. It's not just the wait times and so on. So I think this is sort of patronizing to say that people are only interested in wait times and film times and that type of thing, which is unfortunately a lot of what's being measured right now.

MS. O'SULLIVAN: So what do you sort of see in terms of next steps of things we could start making available to consumers, and then sort of a side question

of that is how useful do you think that's going to be since consumers' choices are so often limited?

MR. KERR: Well, I think Alain has pointed out that unless you give people choice, some meaningful choice, it's difficult. You get frustrated with it. I think choice is definitely critical. I think that's the direction much of the world is going. Certainly CalPERS has offered that type of thing. A lot of the bigger companies now are talking about offering more choices. They're talk about defined contribution. I don't have time to go into all of this. Essentially, they want to offer people more choice at the same time.

Judy here produced interesting work. She's out of the University of Oregon. And she found that when you ask people the HEDIS information, when she actually sat them down and said choose a health plan, HEDIS information is not very important to them. This is the information on the pap smear. Basically what the feeling was, "If I need to get this covered, I can get it."

But what turned out to be of interest to them was people satisfaction. That was of interest to them. And the information on treatment, cause, diseases, things like infection rates and outcomes for mortality. That's what they wanted to know. They said, "If I were to get sick, I want to make sure I go to a good place and a safe place." So I think that it's pretty obvious what consumers really want. I'm not sure we're talking about that.

MS. O'SULLIVAN: My other question is about Medi-cal. What's good for everybody else is good for Medi-cal. Should we be doing more in Medi-Cal?

MR. KERR: I think Medi-cal deserves the attention that everybody else deserves. I think we're all human basically, and the only difference is maybe some cultural issues and how you present the information. I don't think we should do less for Medi-cal. I don't think we should more. We're all human beings. Everybody has a different way in which you communicate the information to. And that's really the difference.

CHAIRMAN ENTHOVEN: Mark Hiepler.

MR. HIEPLER: I like the digressive approach on some of those things. They're very thought provoking. One really easy thing it seems is the level that you're involving consumers, and Ellen did a great presentation a couple meetings ago about the importance of giving consumers information. And we discussed -- because we talk about report cards and all these things.

We've never had anybody come up with the idea that seems rather simple. It doesn't take in electronic criticism for the health plan or the medical groups to actually say what we're paying your physicians for care. I think that's a very important thing. I see this cap rate, and I see this subcap rates.

MR. ROMERO: I'd just like to broaden the question slightly just to fold in with part of it. Financial information generally, lost rates as you

described, capitation rates, or anything else about how your physician gets compensated and how much he gets compensated for your care. This is broadening the question a bit.

MR. HIEPLER: Sure. That's all part of it. I appreciate it. Broadening of that is great. I think that's a very important thing for consumers to know, because most don't even know about capitation. It's a big hidden secret.

I think that's going to help people decide, well, in this plan my doctor gets $5 per month of the capitated rate for seeing that I'm a sick person. I'm not a sick person. Versus this plans that my doctor gets $22 a month as many times as I have to go.

And I'm wondering if that was part of your discussion on the level involving consumers because I want my doctor to be paid. And I don't know where all the rest of the money goes in the health plan, but I think that's a real important thing for consumers, to know how they're paid and what they're paid.

$5 a month to some of these capitation rates force doctors to take quantities of patients and give them to, you know, more less qualified people. I don't know if in your discussions we discussed that.

MR. KERR: We didn't discuss that.

CHAIRMAN ENTHOVEN: I think that is something we do need to take a look at. I think we can only have two more. So we're from A down to Z with

Zaremberg.

Steve, did you have one also?

MR. ZATKIN: Yes. This is on some of the recommendations. I think I like the idea of the task force. For example, we heard about the cost from everybody about electronic information. My question is, I guess, basically, since we're trying to use that information to determine quality, does everybody have to do that to determine quality?

In other words, are you going to get a lot of redundant information so that if you limited the amount that goes to electronic, you don't take money away from the treatment by putting it into this particular type of administration, do you give data that is necessarily redundant.

So I think you -- in a perfect world where we have unlimited resources, fine. But when we're deciding between administration and treatment, we don't need data that's redundant. So I think that's important. Rather then making a recommendation that everybody go to electronic in seven years, I don't know if that -- I just don't know whether that's, you know, in everybody's best interest, and if it gives us data that's redundant at a higher cost.

And I guess the other point is -- I like the idea of implementing, is government the best place to gather data? Is this what people respond to? Do they respond to having information accumulated by their own

plans, their own people they higher as we heard in the last presentation? Do they respond more to those than they do to government?

So I think there's a lot -- I like the direction you're going, but I just have a lot of questions about it. What produces the best results, what we can afford.

MR. KERR: Couple responses quickly. One is that certainly you could do things on sample basis and find out the information you need for evidence, evaluation. But I think that that's really only a small pat of what the electronic medical record can do. And the reason I think it's important that everybody have it is purely quality and improvement.

And there are all sorts of alerts you can put on in this type of system. There's also decisions to important information that you could put on that let the physician know that they can get the diagnosis with the latest information from anywhere in the United States. There's a million reasons why everybody should from a quality of care standpoint have this type of thing.

I think that some of those medical groups that have gotten into doing this that few other groups have done have found it is an initial investment. And the estimates range anywhere from $10,00 to $20,000 per physician depending on the size of the medical group.

But after two or three years, they actually find in terms of the administrative savings alone and in

terms of not redoing things over three or four times, they're actually saving money. So in the end, the fact that you've got everybody on electronic systems saves money over the medium and longer terms as well as the group's quality of care. So I would argue in favor of everybody.

CHAIRMAN ENTHOVEN: Thank you. Last one.

MR. ZATKIN: Yes. Just two points. One on the electronic record, it is a significant recommendation. It's a good goal. I think we do need tests in terms of its impact on affordability and the time input. But what I really wanted to ask you about was the seeming dilemma that exists now, which is that people who are involved in large purchasing arrangements, sophisticated ones, have access to some good, albeit, developing data sets.

CalPERS is one. HIPC is another and so on. But most people are not in those systems. Could you address the question of how we can make available to the bulk of the population that is not part of those systems the kind of information that is available to people who are in CalPERS and HIPC without creating new and additional data sets?

In other words, is there a way we can build on the data sets that are now available and distribute them to people who not part of those systems and perhaps add plans who are not accessible to those systems.

MR. KERR: Of course we're suggesting much more than is being currently done. But the Pacific

Business Group on Health, for instance, you can look under health scope in the internet and get the information that they have. So whatever their employees get, it's also available to the public.

Not everybody is hooked into the internet at this point, but I think we need to think about those types of ways to get the information out. We did not discuss exactly who should get this information out. There's some real questions on who should decide what information, who should then collect, and who should then disseminate it, which we have not gotten into.

CHAIRMAN ENTHOVEN: Clark, I want to thank you and Rodney Armstead. If you would kindly convey to him our thanks for this, I'd really appreciate it. It's a wonderful start.

Then to say to the members in general, please carry on your discussion by telephone. Those of you who didn't get -- or others if you have questions or answers, if you want to discuss this further with Clark and Rodney, I would encourage you to do so.

Then we're going to ask each of our expert resource groups to turn this into a draft for discussion and then to be circulating it, perhaps, first among members of the task force most likely interested. But eventually all members of the task force will see it in draft form and have a chance to interact.

So each of these, while we start with a narrow focus of personnel in part because of our open

meetings, so forth, we hope we will be able to broaden this so everybody will be actively involved in it. Thank you very much. We're off to a really good start.

Next expert resource group is going to be Ellen Rodriguez-Trias and Anthony Rodgers on managed care's impact on vulnerable populations.

MR. RODGERS: Thank you. She and I have had an opportunity to talk about this topic. We would like to solicit your assistance in helping us define the issue of normal population both in terms of what is the definition, what are the characteristics, what other experts we should possibly utilize in developing our section of the documents and help us define the responsibility measures.

I think if -- as we have participated or as I have participated in this process, one of the things that I've noticed is that in our public hearings many of those I would categorize as vocal populations come forth to give us their point of view, and often it has been very insightful and certainly has created a human face on this issue of how vocal populations can participate in managed care and be protected from issues that sometimes have come up in managed care such as specialists, availability of services, et cetera.

So as I'm talking, and I don't want this to be a monologue but rather a dialogue, I'd just like to give you a sense of what our thinking was and where we went with this topic.

First of all, in terms of defining

vulnerable populations, I think you can look at the secular task force, a very broad area. For example, the elderly are a vulnerable population, disabled children, and the poor. And within that there are smaller categories of vulnerable populations. But that starts putting a box around it.

We also thought about -- but there are some populations that are medically vulnerable that cover all those populations, such as people with -- who are HIV infected, people with cancer, asthmatics, as we've heard today, people with long-term chronic illnesses that are on-going and require what you would call significant interventions over a long period of time.

And then the question mark population would be the medically ill, normal population, and the role managed care plays in the services versus the categorical services that are provided. And then we have the episodically vulnerable. That is individuals who have short-term illnesses, intense in nature, who will become vulnerable to what happens.

Do they get access to specialists when needed? Does the system respond effectively to a particular disease episode? And we've heard from, I think, the public where those things haven't gone well.

We have the final broadest, I guess, category, which is the generic socially economically vulnerable, and they typically are the working poor, the medically indigent. And sometimes that relates to the

populations that seek care at the moment of emergency.

And then the population that is vulnerable because of illiteracy. They don't have the educational background to make choices for themselves as easily as, say, those who are literally in the study of issues.

If you look at the groupings, I think one of the questions that we have is: Is it kind of true or false that these populations tend to be in Medicare or Medi-Cal in this state, the categorical programs that are supported by the state government and then public health systems.

And if you look at where the majority of the population seek care, they are within a programmatic area. It tends to be in those programs. And that those programs overlay on managed care certain requirements, et cetera, so you have an opportunity to look at tweaking those programs. What is the percent of the vulnerable population as we described it that really fall in those programs? What is left? How large a group is left, not left in those kind of programs?

The roles in terms of vulnerability, in terms of the systems of care being looked at -- of course there's an administrative fiscal and intermediary role as often played by government in the case of Medi-Cal and Medicare, state and federal programs. There's a regulatory roll. That's a broader industry regulatory role. And there's a market driving role, market forces to apply to generate constant improval. And there's an

advocacy role.

More so than any other grouping, advocates play a very important role in normal population. We have to consider that in writing this section. What role should we legitimize and even put into our thinking as to the role?

Under the administrative role, you have things like controlling the cost of care by reviewing and sending rates; and where you have care arrangement, contracting process, part of the administrative role in the payment systems is deciding on how payments will be made, promotion of the service or program that is actually telling people about the program service, eligibility, et cetera, quality of reporting data submission, eligibility, member communication, agreement resolution. Those are kind of administrative roles that we've heard and we need to address in terms of vulnerable populations.

Regulatory roles, compliance issue being the statewide standards that need to be established so that when people move, move from one system of standards to another in this state, public information reporting as a role of the regulatory responsibility. Kind of the last court of appeals. When I say regulatory, I'm really focusing on the government role, the umpire that sets the ground rules.

And then finally the market facilitator. I think government needs to facilitate the market forces to move in a positive direction. And then finally -- well,

market driver competition and cost -- for cost and quality. And that requires information to be available for people to make appropriate choices. The differentiation of the products; that there is a role for the market to drive a differentiation of the products so that people will have different sites of care, different nuances of that care. Differentiate how one service product is provided versus another.

And what was interesting today, when I was listening to the discussion, is that CalPERS is seeing a consolidation of the plans, that being driven by the fact that people are differentiating the products saying this product is better for me, and so I'm going to go there, and more people are differentiating, and that creates consolidation. Continuous quality or continuous improvement must be driven by the market versus regulated. Grading opportunities for patient needs to be driven by the market.

And finally, this is maybe an issue. Weeding out the poor performance. How is the market going to weed out the poor performance over time? The variance in the quality we use. I think that's what we're hearing a lot of in the vulnerable population, to get into a situation where the services that are being rendered is not up to the appropriate levels.

So when we hear the good things about managed health care, we're hearing, I think, a difference between -- one organization seems to be slanting a certain

way, getting their asthma management program to be very effective, and another organization is not. And should those programs be weeded out over time.

Finally, we talked about the role of advocate. And we see -- an important role of the advocate is an ombudsperson for both the individual and for the, I guess, formal class, formal category, grievance assistance, validation of outcomes.

We think if we get into data reporting, someone has got to be outside the system validating. And then advisory and consulting, and that's a more proactive role, where are the advocates in advising the systems of care in the plans about how to make improvements and when is it really important. So that's kind of framing what we're thinking about as we put this together. And I'd like to ask you to help us look at this issue and get your point of view.

CHAIRMAN ENTHOVEN: That's great. Thank you very much. Comments? Questions?

MR. GALLEGOS: Yes. In your consideration of the vulnerable population, you mentioned -- you kind of defined them in four groups: Elderly, disabled, the poor, and what was the other one, the --

MR. RODGERS: Elderly disabled, children.

MR. GALLEGOS: Right. Was any consideration given to the uninsured as a potential vulnerable population and what managed care's role might be in addressing that group of people in California?

MS. RODRIGUEZ-TRIAS: Yes, we did. We started out with a discussion of basically saying that vulnerable populations could be defined in many way, because -- and they're not exclusive necessarily, because people may have various -- you can be very poor and have cerebral palsy, or you can be very poor and have diabetes.

What was the common denominator was that a person from a vulnerable population was someone who required services beyond -- intensity of services or a quality of services or a kind of service that were more than the norm; that the larger vulnerable population as a group were people who were excluded from the system or the people who, because of the degree of their poverty or other conditions, were covered under Medi-Cal. There was no cutting out of that.

However, this task force has several times, I think, tried to define its function in addressing what managed care needs to do about that. So, you know, given that -- we're not ignoring the total universe, but we started talking about the interface between members of vulnerable populations or vulnerable population groups and managed care.

And so there are gaps that don't even particularly mention that there have been a number of government programs, safety net programs, public programs, that do deal with vulnerable population who are partially covered in managed care as well. So there are gaps in the service. There isn't a full range of services necessarily

in any one given place.

MR. RODGERS: I would just say as you look at the vulnerable populations, especially uninsured, one of the impacts that managed care may be affecting is access of the uninsured because of what it does. And so as we balance what we do with managed care, we have to realize that it changes the system of care for the uninsured because if it consolidates the system or closes the systems of care down because either Safety Net can't continue to provide Safety Net services, so forth, that creates a large vulnerability for that population. That's how we're looking at it.

MR. KERR: Thank you. Other questions? Maryann.

MS. O'SULLIVAN: I didn't hear you mention adequacy of rates as being a key issue to look at for this population.

MR. RODGERS: I didn't specifically talk about it. We are going to look at risk adjustment rates and adjustment premiums based on giving a level of vulnerability. That's how we were approaching it. Yes, adequacy of rates needs to be addressed. We do have it in our more extensive outline to look at risk adjustment and premium adjustment.

MS. O'SULLIVAN: You might want to go beyond that to look whether the rates are adequate to begin with and then within that whether we are adjusting appropriately.

MS. RODRIGUEZ-TRIAS: Yes. We also discussed something else that is really structural and I think very difficult to handle when you talk about people with any kind of special needs, which is what is the common denominator among providers at primary care levels that enables them to address and recognize that those needs are there.

I think this is a real problem in health care delivery, that is, who can do what. And indeed if people can self-refer or are referred through their advocacy organization or some very savvy consumer groups into special services bypassing that variable level of knowledge or ignorance, as the case may be at the primary care level, is that better than having a primary care level that everyone has to go through?

MS. O'SULLIVAN: My other question was about communicating and educating this population and how you see that different from sort of the general communication. What sort of data or information you can get out there and how to get it out there.

MR. RODGERS: Well, that indeed is a problem. Oftentimes vulnerability is also educational vulnerability, ability to understand all of the issues related to a certain disease.

For example, education related to the children. You have California Children Services. And one of the things that has come out over and over again is the role of the parent, because they're the ones that really

need to understand. For other vulnerable populations, I think you have to have specific educational strategies. And I think the systems has -- again, that's a question of differentiation. It all has to end to an outcome of maintenance of health or maintenance of quality of life. And I think you got to back from that.

Okay. This population should have a certain quality of life. What are the strategies, including educational strategies and medical strategies that have to go into assuring that? And where is the observable behavior on the part of whatever the system of care is that is making those efforts? That's the challenge.

Do you regulate that or do you have it driven by a market? And again, that is dependent upon the maturity of information systems, maturity of systems to provide realtime data where people can make choices and the availability of choice. One of the things about vulnerable population is a tendency when there's a vulnerable population for government to (inaudible). Does that reduce choice and increase regulation versus having enough market -- commercial market interests to survey that population?

CHAIRMAN ENTHOVEN: Harry.

MR. CHRISTIE: Anthony, you mentioned the various groups that were vulnerable groups. And in those groups, one group that comes specifically to my mind is the pediatric population. Let's just assume for a moment we're talking about a pediatric population where children

do have coverage as dependents through their parents. Have you identified any issues about managed care which concern you in terms of the delivery of health care to pediatric populations under managed care?

MR. RODGERS: I think in general you can talk about immunization rates, you can talk about preventive care, but what you are trying to accomplish with children is to give them the ability to become healthy adults. I think what you have -- what managed care does, there have been some evidence of immunization rates, there is some success with that because of the relationship that managed care has with prevention.

But I do think we need to investigate other issues related to the service of children because they're vulnerable because they are not the initiator. It's their caring, if you will, of the issues of CHDP examination, prevention, those things that we know. They're vulnerable when they don't have it. For example, the Latino community in Los Angeles, one study shows they weren't given preventive care and identification of eligibility into California services. So they were more vulnerable because of that phenomenon. And so I say their vulnerability is the degree at which we can educate the parent to making sure that child is taken care of.

There may be some vulnerability to certain types of problems, especially for poor children, whether that's child abuse, whether that's an environmental problem, in terms of the environmental issues, children

dealing with lead poisoning, things like that.

And because they are vulnerable, we have to figure out strategies that address those issues. Black people, if I look at the data, I see major variance. I think my concern is I see variance, which means a certain population is not getting the level of interface. And I'm talking about between one managed organization to another.

And in health care where a joint commission or other accrediting bodies have forced a shrinking of mirrors in the health delivery system, because it's been very proactive about keeping the standards in front of the health delivery system and forcing the delivery systems not to have huge variances between one hospital surgery program and another. And that's the question for management.

MR. CHRISTIE: Anthony, just a follow-up to that. Where my questioning was going was children are not small adults. The one thing I'm noticing under managed care, the level of pediatric subspecialty is being reduced significantly. And so my concern would be, how is that reduction in pediatric subspecialty affecting the delivery of care to the pediatric population? And I would suggest you include that in your research.

MS. RODRIGUEZ-TRIAS: Yeah, I absolutely think that's essential. And the other thing I think is important is the degree of coverage for children for their health maintenance needs. People are in and out of coverage in the state as we know. I mean, even if it's

employer-related, and whether they're unemployed or partially, or whether they change site of employment, they may be covered under totally different programs. And perhaps a healthy adult can certainly afford not to see a doctor for several years and won't miss anything.

But for a child where you have to do participatory guidance and you have to do watching of growth development and you have to force the best kind of environment for the growth and development of the child and see how the kid's doing in school and all of that, besides immunization and all the other routine intervention, you really cannot afford to have them --

CHAIRMAN ENTHOVEN: I'll have to cut that one off now and ask Helen if you would kindly lead us into the next phase of our meeting.

Dr. Helen Rodriguez-Trias, who is a task force member, a co-director of the Pacific Institute Organized Health, is going to introduce our other two speakers in the presentation and discussion about managed care's impact on women. Thank you.

MS. RODRIGUEZ-TRIAS: I'm going to read the introductions of the people who are really going to speak and give you a great deal of information first. And then I'm going to do just a very, very short introduction to the subject of why we're discussing women in the first place. And if I may, I'm going to ask Helen Shauffler to step forward and come to the table and also Lucette DeCorde and Debra Kelch.

Dr. Helen Shauffler is the Associate Professor or Health Policy at the University of California at Berkeley for the School of Public Health and Graduate School of Public Policy. She's also the principal investigator of the Health Insurance Policy Program, 1.6 million five-year grant from the California Wellness Foundation to study Californian's access to comprehensive affordable health insurance that promotes health and prevents disease.

She's Phi Beta Kappa graduate, received her master's in health policy and management at Harvard School of Public Health and earned a Ph.D. as a health policy fellow at Brandice University. She testified twice before the Senate Labor and Human Resources Committee hearing on health care reform. And last week she testified before the California State Legislature.

For prior research interest, and some of you may have seen her articles, which have been distributed, her primary research interest is in studying family incentives and systems of accountability which reward in value of the United States health care system based on its ability to improve the health of the American people.

I first heard her speak at the seminar where my organization, Pacific Institute for Women's Health, was working in joint collaboration with the Jacobs Institute with funding from the James Irvine Foundation to do a series of leadership seminars on managed care and women. And she spoke quite a few hours, and I said we've got to

get up for the task force.

Lucetta DeCordee is a director at CEWAER, which is the California Elected Women's Association for Education and Research. In this role, she oversees CEWAER's California Women's Health Project. DeCordee has a master's in public policy and a master's in public health from the University of California Berkeley.

For the past 15 years, she has served the public and devoted her time in the public sector in systems designed in health and social services. Her employment experiences include community-based nonprofit organization, state, and local government and private health plan organizations. She's a member of our collaborating group for the California health report cards. And we have worked very closely together.

Joining the set today, Debra Kelch. She is a policy consultant. She has worked for both the senate and assembly agencies and for the office of legislative analysts from 1990 to 1994. Ms. Kelch served as policy director for the California Association of HMOs. Ms. Kelch has a master's in public policy and administration from USC Sacramento.

Thank you so much. I just want to say a couple of words on why women? In this we ask the question.

I think primarily the issue of women in managed care is that women are the principal consumers of health care in the country, and therefore have the most to

gain or to lose from how managed care works. They're not only the major consumers for themselves, but also they are the consumers for their families. It is women who bring the children in, who very often bring their husbands in and who as caretakers of the elderly relatives and other people have interfaced with the health care system very often.

They're also the majority of the workers in health care for the work force. So that really makes for a particularly important relationship. But there are other aspects about the importance of women, vis-a-vis managed care, is that women as a group and as a movement which first were merged as a major organized consumer group making demands upon their health care system.

And if we look at many of the consumer driven organizations, they were started by women as advocates for their relatives and particularly for children with special illnesses and so on. In fact, women have been very fundamental in actually shaking the health care agenda as well as the health research agenda in the past decade or so.

Women need services and preventive interventions throughout their life span, but particularly during their reproductive years that in a way forces the utilization and the frequent utilization, and it really is essential in terms of health preservation. But besides that, there is no other group whose health care is so much intervened in relationship to ideology.

And there have been a great many studies about the trivialization of women's complaints and concerns about the differential treatment of woman, vis-a-vis chest pain and other presenting complaints as compared to men, the bias that may be inherent in some of the cultural settings in dealing with women, and the ideological impositions that we see in curtailment of access to reproductive health care services and reproductive rights. I don't believe there are providers in any other field who are getting killed or shot at because they're providing abortion services for women, for instance.

So that makes for a very particular relationship where ideology and politics play a very important role in shaping what happens with women and for women within managed care and other health care.

And finally, I've got to say, we are here because we have arrived -- I don't know, many of you may have seen, there was a full supplement in the New York Times that was entitled "Women's Health." So I guess that's it with that.

CHAIRMAN ENTHOVEN: Thank you, Helen. I'm sorry. I didn't introduce Clark Kerr's session by pointing out it was a famous woman who instituted -- who started the Health Outcomes Measurement Movement, also. I'm referring to Florence Nightingale, of course.

DR. SHAUFFLER: It's a pleasure to be able to here this morning and share with you some of the

findings regarding women's experiences in managed health here in California.

The presentation that I will discuss this morning will focus primarily on primary and preventive care for women in California. And this work was conducted as part of the Health Insurance Policy Program, which Helen referred to, which is funded by the California Wellness Foundation. And this is a collaborative project between the University of California Berkeley and U.C.L.A.

And the purpose of this project is to collect data on the state of health insurance in California that's useful to policy makers in making decisions about improving the health care system here in California.

I think all of you in your packet have a copy of the report that we've produced this year. We're producing a similar report every year for the next five years. And I think you also have a copy of the slides that I will be showing you this morning.

The data we used -- or at least I'm going to present this morning are from two different sources. The first is every year we participate in the California Behavioral Risk Factor Survey, which is a CDC sponsored survey implemented in all 50 states, and we have funded the addition of about 20 additional questions to get much more detailed information about managed care, about their health promotion and disease prevention utilization and to get information about their employment that can help us

begin to look at the relationships between health and employment and insurance.

We also do at UC Berkeley a survey every year of all of the Knox-Keene licensed HMOs in the state of California and all of the licensed health insurance carriers that sell comprehensive PPO and indemnity products in the state.

This slide has a lot of information on it. But I basically want you to see the overall pattern from this data. On this side, you can see right away looking at what's covered in the standard medical packages are the best selling plans offered here in California by plan type. But there's quite a bit of variation depending on the type of plan that it is.

And that in fact nearly all of the HMO and point of service plans cover routine physicals, cholesterol screening, STD screening, health education, health promotion, and adult flu vaccines. And among this list, only two were not covered by 100 percent of the HMO and point of service plan. And these were health promotion programs and adult flu vaccine. We're experiencing from 89 to 94 percent, which is quite high.

MR. ROMERO: Just a second. The denominator in this ratio is the number of plans?

DR. SHAUFFLER: Right. In 1996, there were 35 Knox-Keene licensed HMOs.

MR. ZATKIN: When you say that point of service covers these, do you mean that both in plan and

out of plan point of service or just --

DR. SHAUFFLER: What we asked them was for their best selling point of service plan in California, whether these were covered in the plan for their best selling product.

MR. ZATKIN: So if I'm a point of service member, and I were to go out of network --

DR. SHAUFFLER: We didn't ask whether it was covered out of network.

MR. ZATKIN: I believe there are different ones.

DR. SHAUFFLER: Yes, there are. This is just in network.

Okay. The coverage to these same benefits as Alain so rightly pointed out in both PPO and particularly in the indemnity plans offer a different story. And while at least three-quarters of the PPO indemnity plans cover cholesterol screening, health education, health promotion, and adult flu vaccine, less than 80 percent covered STD screenings. And in fact, what's interesting here, most surprising to us, is that the PPO benefit package was consistently worse even than the indemnity plans in covering preventive care.

My colleague Jamie Robinson at the University of California Berkeley refers to PPO plans as poor man's indemnity. They may be the rich man's PPO, but they're the poor man's indemnity. And our data tend to reflect this observation.

In this next line, we compare benefits specifically for women's health by plan type. And again, we see the same pattern. All of the HMOs and point of service plans cover mammograms and pap smears, but coverage for family planning and preventive counseling are not as prevalent. Similarly, the PPO indemnity plans are less likely to cover women's health care.

I think we can conclude that at least as far as preventive benefits are concerned, women in California get much more value from HMO and point of service plans than PPO and indemnity plans. HMO and point of service plan premiums are lower, and their preventive benefits packages are richer.

This slide shows the percentage of women 50 years and older in California who received a mammogram in the last two years. 74 percent of women ages 50 to 64, over 50 with employer-based insurance. And 73 percent of women with Medicare have received a mammogram in the last two years. But this still means that about one-quarter of all women with insurance coverage are not receiving a mammogram as recommended every two years.

And the situation for women in California without health insurance is far worse. Only 57 percent of women 50 years and over have had a mammogram in the last two years.

The rates for clinical breast exam are considerably lower than for mammography rates. For women 50 years and older, only 67 to 69 percent of women with

employee-based or privately purchased insurance have had a clinical breast exam in the last year. And an appallingly low 19 percent of uninsured women have had CBE for early detection of breast cancer in the last year.

On this slide, you see this percentage of asymptomatic women 18 years and older without hysterectomies who have had a pap smear in the last three years, women with employer based or privately purchased insurance have the highest rates, 91 to 93 percent, which is quite good. And women covered by Medicare and Medi-Cal have slightly lower rates of 83 to 88 percent. And once again, we only see that 68 percent of uninsured women have had a pap smear in the last three years.

This slide prepares the rates of preventive service utilization for women with health insurance as a function of their type of health plan. And the stars indicate statistically significant differences so that you can see that HMOs do a significantly better job of providing mammograms every two years compared to PPO and indemnity plans. And indemnity plans do a significantly poorer job of providing clinical breast exams --

MS. BOWNE: Excuse me. I believe rather than providing the care, it's whether or not the service is covered.

DR. SHAUFFLER: Well, I already showed you the covered data. This is actually whether they've received the care.

MS. BOWNE: Received.

DR. SHAUFFLER: Yes. There are two different sources of data. The data on what the health plans do are from our health plans survey, and the data on what care is received is from the California Behavioral Risk Factor Survey of the population.

So as you can see, the indemnity plans then do a significantly poorer job of providing CBE and pap smears compared to the HMOs. But there were no significant differences in the rates of women who had checkups in the last year or the last two years across plan types suggesting that there are real opportunities being missed when women are in for a checkup and providing them with the clinical preventive care that they need.

Dr. Susan Blumenthal, which is the deputy assistant secretary for women's health at the Department of Health and Human Services has noted the changing health-related behaviors should be a woman's chief health concern.

In fact, she goes on to remind us that about 50 percent of the top killers of women are behavioral and life style related. These include smoking, drug abuse, alcohol abuse, poor nutrition, lack of physical exercise, and unsafe sex.

We wanted to know to what extent the health care system and the managed care plans in California were encouraging women to change their behaviors by offering them health advice or increasing access to health promotion programs.

This slide shows the percentage of women in California who have been counseled about specific health behaviors and risk factors by their health care provider in the last three years as a function of type of health plan. The first thing I'd like you to notice is how low all of these counseling rates are.

The vast majority of women in California are not receiving counseling on any one of these important risk factors. Rates of counseling for women addressing their diet and nutrition range from 30 to 31 percent; for drinking, from 7 to 11 percent; for exercise, from 32 to 35 percent; for smoking, from 16 to 18 percent; for sexually transmitted diseases and HIV, from 12 to 16 percent; and gun safety, only 3 to 4 percent.

Clearly, I think the incentives must be changed to increase counseling rates for women about their health behaviors when they visit their health care providers. There were no significant differences in counseling rates for women by plan type for exercise, diet, smoking, STD, HIV, or gun safety. Rates in managed care and indemnity plans were equally low. The only significant difference we observed was that women in indemnity plans received counseling about alcohol use at about half the rate of women in HMO and PPO plans.

CHAIRMAN ENTHOVEN: Excuse me.

MR. NORTHWAY: Do these rates differ than what we see for men?

DR. SHAUFFLER: I didn't look at men. In

our report, I looked at the whole population. I've done a special analysis for women. I haven't done one for men.

DR. NORTHWAY: Did you look at all of the information, or is this strictly --

DR. SHAUFFLER: This is whether any health care professional has talked to you about each of these things in the last three years.

DR. SPURLOCK: And the plan was providing information directly to a woman that was not counseled?

DR. SHAUFFLER: No. I mean we do have information about whether they do newsletters and things like that, but we wanted to know whether there was a conversation.

MS. DECKER: One other question. Was there any adjustment in here for people that were perceived to be at risk?

DR. SHAUFFLER: We did some adjustment risk, but there's a real debate about whether one should do that or not. Shouldn't you talk to a woman about smoking even if her husband smokes to let her know that secondhand smoke might be harming her children? I mean, secondhand smoke is also a big issue and important to discuss with people. And so it's not just the smoker that should be the target of those conversations.

MS. DECKER: Okay. Gun safety is the one that I just don't get.

DR. SHAUFFLER: It's a concern about domestic violence and children.

What's most interesting, I think, is that most women in California have had a checkup or periodic health exam at least once in the last two years. 94 to 98 percent with any type of insurance have had a biannual checkup. Again, I think we're seeing important opportunities that are being missed to provide preventive counseling within the context of the primary preventive care visit.

Women by and large are getting their periodic health exams, but they're not receiving all the preventive care that we need. And again, we see uninsured women have fallen through the safety net in California for primary care with only 47 percent having had a checkup in the last two years.

In our 1996 survey of health plans, we also asked the plans about the types of health promotion programs they offer to their members. Here the differences between HMOs and PPO indemnity plans is striking with 90 percent of HMOs offering programs for women in prenatal nutrition and 80 percent offering smoking cessation programs compared to 53 percent or less of the PPO indemnity plans.

However, the proportion of plans that offer health promotional programs beyond these two falls off fairly precipitously with only about 60 percent of HMOs offering programs in physical activity, adult immunization, and dietary fat. And rates for the PPO indemnity plans were considerably lower with 20 percent

offering programs in dietary fat and adult immunization. The previous slide, in fact, was the good new.

For blood pressure, substance abuse, STD prevention, and HIV, AIDS prevention, only about 50 percent of the HMOs offer any health promotion programs. And for the PPO indemnity plans, 27 percent or less offered programs. Only 13 percent promotion programs for HIV, AIDS prevention. Mental health promotion programs, such as stress reduction was the least available with only 43 percent of HMOs and 7 percent of PPO indemnity plans offering those programs.

In terms of how comprehensive the programs are, we considered plans that offered zero to four programs as limited. Five to ten out of the 12 that we looked at is moderate, and 11 to 12 is comprehensive. As you can see, 77 percent of the HMOs offered moderate to comprehensive programs compared to 44 percent of the PPO indemnity plans.

And this difference is even more visible when you look at just the proportion who offer comprehensive programs with less than a third of HMOs and less than 10 percent of PPO indemnity plans offering comprehensive health promotion programs to women who are members of the plan.

Despite all of this plan activity, however, women's participation rates in health promotion programs are extremely low. Only two to three percent of women in California report having participated in any health

promotion program offered through their plan. We also found no differences in rates of women's participation in programs by plan type despite the difference in their availability by plan type.

Low participation rates in health promotion programs raised for us the important question of whether or not HMOs are offering health promotion program primarily for marketing purposes to increase enrollments and enrollee satisfaction or whether they are serious about reducing health risk, improving health, and reducing health care costs through disease and injury prevention. Our findings with respect to the HMO efforts to evaluate their health promotion programs begin to shed some light on this important question.

Our data suggests that for a majority of HMOs, health promotion programs are offered primarily as a marketing vehicle. Most health plan evaluations of their health promotion programs are limited to member satisfaction and tracking utilization rates.

However, a substantial minority of HMOs in California, 35 to 45 percent varying by the outcome measure that we looked at, are engaged in much more serious efforts to evaluate the impact of their health promotion programs on changes in enrollee health behaviors, health status, and medical care costs.

Thus, for more than one-third of the HMOs in California, our findings suggest that health promotion programs are more than marketing devices, but one means of

achieving other goals important to the organization in terms of healthier populations and lower health care costs. I think we need to find a way to get the majority of HMOs to adopt these goals as well.

So to conclude, the HMO and point of service plans compared to the PPO indemnity plans in California are much more likely to cover comprehensive clinical preventive care for women and to offer comprehensive health promotion programs. However, even in the best selling programs in California, many of the benefits that are important to promoting and improving the health of women are not routinely covered, including mental health and substance abuse services, pharmaceuticals, and family and birth control.

In addition, women in HMOs and PPO plans are more likely to receive recommended clinical preventive services compared to women in indemnity plans. Yes.

DR. GILBERT: I guess I'm a bit surprised at the pharmaceuticals. Are you saying most of them don't supply drug benefit at all or --

DR. SHAUFFLER: No. There's great variation across plans on the extent to which they cover pharmaceuticals. In other words, you wouldn't find 100 percent of plans covering pharmaceuticals. I didn't bring the data with me. But there's much more variation, and it's substantially below 100 percent regardless of the type of plan.

DR. GILBERT: You mean in the HMO category?

DR. SHAUFFLER: Yes. Okay. So in addition, women in HMOs and PPOs are more likely to receive clinical preventive care, pap smear, and the clinical breast exam are much less likely to receive an indemnity; and for mammography, more likely to be received in the HMO. Counseling women about their health behaviors is probably one of the most important things that managed care plans can do to improve the health of women in California.

But the proportion of women that received any counseling in the last three years ranges from 45 to 60 percent with fewer than 20 percent having ever received counseling on the smoking, alcohol, STD, HIV prevention regarding safety.

Health care plans in California need to increase accountability for incentives to providers to increase their rates of preventive counseling for women. The major risk factors responsible for the future health of the women in California are not being adequately addressed in either managed care or indemnity plans. There are important differences in what women need versus what they receive from their managed health care plan in California.

MR. ROMERO: I can't change it.

DR. SHAUFFLER: That's all right. I will tell you what it says. Health plans in California do a much poorer job of providing services to prevent heart disease and other leading causes of death through efforts to change life style behavior. Heart disease kills more

women in California than all cancers combined. In fact, between the age of 40 and 60, as many women die of heart disease as they do of breast cancer.

Prevention efforts in managed care plans in California need to begin to put as much emphasis on preventing heart disease in women, detecting it earlier, and treating it appropriately to the same degree if not more as their efforts to detect and treat breast cancer. The managed care system in California also needs to focus more on encouraging women and supporting them in their efforts to change their health behaviors and by -- in addition to providing them with clinical preventive care.

And finally, managed care plans in California need to start doing a much better job about talking with women about their risks and health behavior, particularly as they relate to substance abuse, domestic violence, diet, and exercise. We know a lot about what women's health care needs are, but this knowledge has not yet been transferred into the polices and programs of health plans and into the practices of health care providers in managed care plans in California.

Finally, I just want to say one last word about the uninsured women in California. Research suggests that uninsured women are in fact a vulnerable population, as they're significantly less like to get routine, primary, or preventive care or to participate in health promotion programs to improve their health. They're also more likely to have unhealthy behaviors and

to be in poor health status.

Lack of health insurance represents a significant barrier to these women to get the primary care and preventive care that they need. In addition to improving the managed health care system in California, I'd like to see us also work to begin to provide health insurance coverage and increased access to comprehensive quality managed care programs that promote health for all Californians. Thanks.

CHAIRMAN ENTHOVEN: Thank you very much, Dr. Shauffler.

DR. SHAUFFLER: I have a question from someone in the audience. Is that appropriate?

CHAIRMAN ENTHOVEN: I request that we hold off. Let the task force members, please.

Any questions from members of the task force?

Yes, Dr. Alpert.

DR. ALPERT: Actually, the flow of all of our meetings, but this one really highlights in particularly -- and not simply your presentation, although it gives us good place to start -- the inextricable linkage between two issues. One of which was -- relates to the wave of unhappiness and so forth and so on which seems to be related to HMOs and why that is. I sense that you're going to be helping us doing the survey certainly. And I know we're going to hear more about that.

I'm actually quite interested in that,

because I think that might be getting towards the answer to that question. And in the other part of this, which we we're having a large conference on today, which is essentially medical care, what should -- what people need and to what practice guidelines, outcome studies, and all of those laudable things.

And those two may be very different -- be very different things. I'll give an example. The best example of what people need, if we assume everybody wants better health, it goes back to Susan Blumenthal's comments about life style, which of course applies to men as well as women.

You're telling us about heart disease in women. Of course, heart disease is the No. 1 killer every year in this century, except in 1918, of men and women in this country. So that's been around for a long time and we certainly need to do that.

That's very different than things that were pointed out before by Clark. For instance, with the phenomena -- the paradox, if you will, that patients who are the sickest, given the system that we have now, may potentially not have access to physicians or hospitals because of redlining hospitals, not getting contracts, physicians being penalized for having the sickest patients, which might be the source of a survey result in terms of what makes people unhappy.

And I don't know -- this isn't just a question. This is more of a comment about the two issues

that we're having. And I'm just looking forward to this survey to deal more with the result of why are people happy or unhappy versus --

DR. SHAUFFLER: I have actually done some analysis on looking at the relationship between availability and utilization of health promotion programs as well as whether or not an individual receives counseling about these heath topics and their satisfaction with their plan.

And in both cases, there were very strong and significant relationships controlling for a myriad of other factors so that whether or not they're even using those services if they're available, it's somehow sending a signal to the consumer that their plan maybe cares about them. What I'm concerned about, we want more than signals. We want results.

DR. ALPERT: What brings me back to CalPERS is what I see now as a great laboratory, because in this sea, this seems to be a little island, unless I'm misunderstanding what I heard this morning, where not only are costs being cut down, but people seem to be getting happier and happier.

DR. SHAUFFLER: I don't know if they're getting happier and happier. But the Pacific Business Group on Health has the same data in terms of being able to lower premiums and also maintaining satisfaction levels and working to improve quality. So they're not alone.

CHAIRMAN ENTHOVEN: Let me just say to

everybody here, we have about 15 minutes to go until our scheduled break, which we ought to adhere to, because we're going to have to be back here at 2:00. And Alice has just informed me there's no snack bar in the area. Maybe there's a grocery store just to go buy a candy bar and Snapple. They're all closed on Saturdays, so we may have trouble getting fed. So I think we need to respect our 1:00 o'clock closing. But Helen, you're going to be talking about the survey. And then also, you kind of manage how best to deal with that, or should we set a talk --

DR. SHAUFFLER: I think it would be best if we continue with the women's health and maybe wait for anymore questions until after the rest of the presentation has been made. I was told only to take about ten minutes for the survey.

DR. GILBERT: Just very quick. On the counseling, could that have been anybody including their primary care physician --

DR. SHAUFFLER: Yes. Any health care professional, doctor, nurse, nurse practitioner, any health care practitioner.

DR. GILBERT: Anyone. Okay. Because I think that's very important, because theoretically, back to your point, Dr. Alpert, some of this should be the role of the physician to provide that kind of counseling and intervention separate from any health plan program.

DR. SHAUFFLER: I think the problem is if

you tried to talk to all the things, you couldn't examine them. So there is a role for, I think, other kinds of health care professionals to also talk to their patients.

CHAIRMAN ENTHOVEN: Okay. Rebecca.

MS. BOWNE: That's okay.

MR. WILLIAMS: I'm curious in the analysis of comparing health plans, which are HMOs who really arrange for care versus indemnity plans that really reimburse the individual members or the health care professional. It seems like there's a bit of a comparison of apples and oranges. I think from the members' point of view, at the end of the day, they'd like to know whether they're getting the service or not.

But just in terms of how the system improves its performance, it seems like we're comparing two things that are a little bit different. Second point is -- I know many of the health plans I'm familiar with, I spent a good deal of time communicating with board members in writing about things like diet, alcohol, exercise, are all kinds of newsletters that encourage those members who do have a need to bring those issues up with their primary care physician. I needed some comments on those issues.

DR. SHAUFFLER: The vast majority of plans do have these newsletters. Newsletters are a good way to communicate information, but they're not a good way to change behavior. So I think they are certainly of value and a vehicle to inform people about what they should be doing, and even inform them about what's available to them

if they want to try to make a change, but information alone will not change behavior. And behavioral sciences, I think, pretty well established that.

The other part of your question I wanted to answer in terms of the apples and oranges, one part of the system that is in fact unique in terms of how it arranges for health promotion services are the staff model HMOs where frequently they can offer those programs in-house. Kaiser, for example. Whereas if you're looking at IPA or network model HMO, they're not providing that in-house. They're contracting out with someone else to provide that service for them. And similar arrangements would be made under an PPO or indemnity kind of plan. So it's only staff model HMO that's really unique in its ability with it or the medical groups themselves who offer programs in-house. But those are -- they're not offered by the health plan per se.

MS. BOWNE: Yeah. I think that's an equal problem with your survey methodology and, with all due respect, to your credentials. I would say that the Association of California Life and Health Insurers would say that when you ask the question what's included in your standard benefit package of indemnity and PPO plans, health education and health promotion are not included, but that does not mean that the plans do not provide them through newsletters. So I think part of the problem here is both in either your lack of understanding or the way you formed the question.

DR. SHAUFFLER: I honestly don't think so. I think what we're asking --

MS. BOWNE: I think we'll agree just to disagree.

DR. SHAUFFLER: Well, I would respectfully submit that I do understand the difference.

CHAIRMAN ENTHOVEN: Clark. Last question.

MR. KERR: We had some data on who offers programs and counseling. Is there any prepared data on who actually made health improvements? Like who got better -- is that critical? Who actually got people to stop smoking? Who got blood pressure down?

DR. SHAUFFLER: We don't have that type of information right now. And there's a large debate in the health promotion community to what extent you can hold the health plan accountable for that outcome. Certainly you want them to be doing everything that is known to be effective within the context of the clinical encounter and access to behavioral programs that will assist that person.

But there are so many other variables that affect the individual's decision to smoke, like whether their spouse smokes, whether they're allowed to smoke at work. There are so many other variables that to hold the health plan solely accountant for whether or not the patient quit, it's not clear how much responsibility we should put on it.

I think we want to look at quit rates, but I

think there is this important question of whether we can hold them accountable for changing individual behavior. We just want to hold them accountable for doing everything that's scientifically known to be a factor to change behavior.

CHAIRMAN ENTHOVEN: Thank you. I just offer a concluding comment. That is as between HMO and PPO, there is no law that requires employers to offer HMOs anymore. And they always do have the alternative of falling back on self-funded, therefore non-regulated PPOs. I think it's reason, we need to be careful not to load cost burdens on HMOs that will make them non-competitive with self-funded non-regulated PPOs.

Were you going to say something?

UNIDENTIFIED SPEAKER: No.

CHAIRMAN ENTHOVEN: Let's go to the survey. What we're hoping to accomplish, to answer Dr. Alpert's question, is to understand in a quantitative sense what it is that is bothering whom about managed care in order to be able to identify more specifically what the problems are in a way that might lead to constructive recommendations.

I believe we've all heard lots of complaints about managed care, but it's hard without a survey to quantify that and find out what's the most important. Also, we want to look into the question, if you have a problem, how does the system fail in not providing you relief. That is, if you go to your health plan, where you

seek assistance, did that not help you in order to better understand the failings of the supported safety net?

Go ahead.

MS. DeCordeE: My name is Lucette DeCordee. I'm going to abbreviate my remarks, but you will find my remarks along with Debra Kelch's testimony and executive summaries of some of our reports in the white packet that we've just given to you today. That includes a very hot off the presses reprint of our topic guide on the impact of health care reform on women, as well as an executive summary our findings on women's mental health needs and a report on older women's health that Ms. Kelch is going to provide some highlights for you specific of our findings and recommendations as they apply to managed care.

I want to make two points very quickly, and they've been touched on a bit today. One has to do with mental health needs in general and women's mental health specifically. We want to acknowledge that mental health benefits for the most part are woefully inadequate and that there is a growing movement both within this state and across the nation to take a look at plans inserting parity for mental health benefits so that they would not be disproportionate to other physical health benefits the way that they exist now.

We have seen, for example, when you look simply at depression, there was a study conducted recently comparing depression with six major medical conditions. And depression was found second only to severe heart

disease and its association with disability and the interruption of daily functioning.

It's important to note that women are three times more likely to suffer from depression, so there's tremendous impacts there for us to address. We also know that for those who turn to the public sector for care, there is minimal refuge because of the changes of funding that now focus on the most persistently and severely ill, and increased public pressure to address within that public sector those who are the most violent. That happens to be men.

In addition to that work, we've seen some estimates now from a variety of studies that are consistent with congressional budget office estimates. The premiums would increase by probably about 4 percent should parity be provided for mental health services.

Secondly, to touch very briefly on some of our concerns with how women are impacted by health care reforms, we would like to point out that women have significantly less access to health coverage due largely in part to their employment.

Women work more often on a temporary basis or part time or who have their work patterns interrupted by periods of caregiving for children, parents, and a variety of other people. The least likely working women to be insured include those between the ages of 19 and 24, those who work in the pink collar traditional female occupations. Those working in the small businesses,

Latino and African-American women, and those women who are in the minimum wage income.

CHAIRMAN ENTHOVEN: Excuse me. I hate to do this, but we do have to reserve some time for the survey. So I would appreciate if you could kind of wrap it up, especially if it's in the written material.

MS. DeCordeE: I will do that, yes. I will turn over at this point -- I'm going to introduce Debra Kelch, who's going to highlight our older women's findings.

MS. KELCH: Thank you very much for the opportunity to be here today. I do understand the time constraints you're under. I would like, however, to take the opportunity to highlight for you what I think are some very important pieces of information about the role of women's health, and in many instances, it's a lack of importance to policy makers and decision makers. We thank you for giving us the opportunity to talk to you in the hope that that will not be the case of the task force visit's work.

I'd just like to add to what Dr. Rodriguez-Trias said about why you would even have this on your agenda. I think it's pretty important, and I would like to emphasize it.

Men and women have very different health profiles and health experiences as they age. American women live longer than men, but experience greater chronic limitations. Older women access a very different mix of

health services. Elderly men and women use about the same number of physician services, but elderly men use more hospitals.

Importantly, elderly women make greater use of prescription drugs and long term care services, which are typically not covered by Medicare. Older women bear most of the grunt of escalating health care costs since they live longer and require services typically not covered. Their out-of-pocket costs are higher than older men, and they typically have fewer resources to pay for health care. Older women of different social, different economic background, life styles, and racial and ethnic groups as a law have very different health care experiences and histories requiring different health policies and programs.

There is evidence that physicians pursue less aggressive treatments with women, especially older women, and many physicians are unaware of key issues affecting the treatment and prevention of illness in older women. Women are less likely than older men to have diagnostic tests and procedures even when the presenting symptoms are identical.

Across a broad spectrum of illnesses and conditions, the health problems of older women have frequently been undiagnosis, misdiagnosised, under treated or left untreated. Importantly, many of the health problems -- most of the health problems of older women are preventable through healthy life styles and early

screening detection and treatment.

You may ask what about this is important for your deliberations on managed care. I think there are two primary reasons. The first is because older women tend to be more vulnerable and more disabled as a group than older men or younger men and women. And because there is still limited and conflicting information on outcomes and managed care, it is important that thorough planning, careful monitoring and review be in place as managed care is extended to high risk groups.

It is critical that the special health care needs of older women are understood and taken into account as programs move ahead in monitoring that placement programs are implement. Since older women have experienced under treatment, under diagnosis, and misdiagnosis in traditional fee-for-service, we must be vigilant as they move to the more tightly managed care arena.

The second reason, in addition, managed care plans, particularly HMOs are organized system of care with a stated focus on prevention, more comprehensive benefits and an opportunity to communicate directly with networks on physicians on care protocols and the appropriate treatment and prevention.

Therefore managed care systems have the potential to mitigate and improve some of the traditional practices of the medical care system when it comes to the prevention and treatment of illness in older women. My

testimony in the executive summary that you have lays out in a pretty systematic way these issues of misdiagnosis, under treatment, and lack of treatment for older women, but I won't detail those today unfortunately. I hope you do have a chance to look at it, because I think it's quite profound.

Essentially, the findings of our report underscore the prevalence of these problems in women's health in the medical care system. One that I'd just like to highlight for you in recognition of your time is the issue of medication errors.

Older women are especially vulnerable to medication errors and drug interactions since they are more likely to suffer from chronic conditions, multiple chronic conditions, than older men. Older women take an average of six prescription drugs and three over-the-counter medications at the same time. Medication misuse and inappropriate prescriptions can lead to drug toxicity or physical and mental disorders.

In addition, physicians continue to misdiagnosis of alcoholism in the elderly. Speaking about the health coverage programs that older women have and trying as best I can to shorten my testimony pretty dramatically, I would like to say that most older women are, in fact, covered by Medicare, but traditional Medicare provides better coverage for the acute illnesses of men than the chronic illnesses of women. And because older women are more likely to have lower incomes, and to

use resources in prescription drug costs and long term care, they spend a greater portion of their income on out-of-pocket medical care costs.

As you know, in California I had -- you have in your packet the different slides we intended to show. I wanted to just kind of use one of them. Essentially, this is information -- I just had a recent opportunity to look at the HCFA data for the December 1996 reporting period, which included all of the individual enrollees in California health care plans.

What this slide shows is that in terms of comparing the total pool of Medicare eligibles to those persons who select Medicare risk plans, you can see that with the exception that Medicare plans are not currently covering those person 65 and under.

Basically, the age breakdown of persons selecting risk plans is pretty consistent to the general Medicare population. There is a smaller proportion of those persons 85 and older that are most likely to have serious chronic health problems that are selecting risk plans, but it's a very small difference.

To jump quickly -- the one thing I do want to mention, as you look at your appendix D that has this chart, you will see that it compares with fee-for-service risk plans, and I changed it to eligibles because I wanted to more closely reflect the data that's not the fee-for-service enrollees so much as it is the total pool of Medicare eligibles. So when you look at that, if you

change fee-for-service to eligibles, it will be more accurate.

If I could highlight briefly some of the recommendations, I do, again, hope that you have the opportunity to review our materials, none of which are long, but all of which are important. Given the potential for financial incentives to result in care restrictions and limits on needed services, any plan to expand the use of managed care for special populations including older women should be carefully designed and monitored.

As policy options, we suggest to you the Department of Health Services and Corporations should develop strict guidelines and quality measurement for managed care plans serving elderly and disabled persons similar to standards implemented for health plans enrolling low income women and children.

Standards should include evaluation of plan compliance with specific health screening prevention and health education guidelines for older women and implementation of cultural linguistically appropriate service delivery.

As you consider the development of quality measurement programs, please be aware it is important that quality reporting include data and monitoring of compliance with preventive and treated standards for subgroups within population, such as gender, age, and ethnic information to ensure compliance for high risk populations and to permit effective outreach in targeting

programs.

Policy makers should encourage congress and the president to include reasonable and enforceable standards for financial solvency, consumer disclosure, sufficient access to primary and specialty care, meaningful quality measurement for all plans participating in Medicare, including the proposed new plans or organizations that may not be subject to state licensure.

Consumers, including older women, need objective ongoing information regarding HMOs. The roll of government can and should be to create consistent quality standards in recording the cross plans. Although health plan standards and quality reporting should be consistent, government compliance should not reduce the ability of health plans to provide unique and targeted programs for special population.

Provider education and licensure standards should include ongoing education and training on the prevention, detection, and treatment of health problems affecting older women. Any state level task force advisory committee or planning group should focus on -- that's focusing on health care and health care delivery should include participation by individuals and organizations representing older women.

In conclusion, given the growing population of older persons and the dynamics of change in health care, it is necessary to develop a multi-faceted approach to the problems of discrimination experienced by older

women and women in general in the health care system. This approach requires both patient and professional education as well as public and private policy changes.

Health policy and programs should be carefully scrutinized at every step for the specific impacts on older women in light of the evidence that older women have very different health care needs and experiences. Government can play a significant role, and I know this is a question that you're all asking yourselves, in encouraging attention to the needs of older women through the funding and regulatory programs that are implemented and through the standards and quality reporting requirements that it imposes.

I would like to thank you again for the opportunity to be here. It is in many ways a historic opportunity. And we do hope that you'll have the opportunity to consider the information you've been provided with. Thank you.

CHAIRMAN ENTHOVEN: Thank you very much. Task force members --

MS. SUTHERLAND: Mr. Chairman, may I interrupt? My name is Shannon Sutherland. I'm with the California Nurse's Association. This information is vitally important for me as a woman as a member of the health plan HMO. I would like to recommend or suggest to the task force that this group be given additional time or another time to demonstrate to the task force their information. I'm just concerned with the time constraints

that you would not all get the information that they have to offer. And personally I think it's important. I would like additional scheduling so they could give their whole presentation.

CHAIRMAN ENTHOVEN: Well, we do have the full presentation in writing. I certainly intend to study it. And we will consider that carefully as to whether that should --

MS. SUTHERLAND: I'm just concerned this will get lost. And where you're going to be making recommendations about the health care, I think it's important. And personally I wanted to hear their entire presentation.

CHAIRMAN ENTHOVEN: I don't doubt the importance, and I don't think anybody on the task force does doubt the importance. We will study the written material, and we will take a look at whether -- how to carry this forward. We do have a special group looking at health services for vulnerable populations, and they may well include that.

Any other questions or comments by members of the task force?

Now, we do have a real problem about what to do about the survey. And the problem is we do have a long afternoon ahead of us. So I think it's wise for people to have enough of a break to grab a sandwich or candy bar.

So I've been asking staff -- I would like to do the healthy thing and go have a salad. There isn't

going to be time. So I've been asking staff here for advice on how do we deal with the survey, and one suggestion that I think we'll try to implement is, with public notice, we will try to set up two or three scheduled conference calls at which members and the public can call in and participate and interact with Dr. Shauffler about the survey.

The main issue when we have been discussing it among ourselves has been to be sure that the survey is done in such a way that it gives us some information and insight about where the most important problems are to help prioritize that.

Diane, you looked expectant, as if you're about to say something.

MS. GRIFFITHS: We're not going to discuss the survey at all?

CHAIRMAN ENTHOVEN: Well, what do you think we ought to do? Forego lunch? We have a long afternoon ahead of us.

MS. O'SULLIVAN: How about taking the first 15 minutes in the afternoon.

CHAIRMAN ENTHOVEN: I asked Dr. Romero who had some problems with that --

MS. O'SULLIVAN: Well, how about if we go 15 minutes now and begin the afternoon session 15 minutes late?

CHAIRMAN ENTHOVEN: Our parliamentarian is telling us we can't do that. We did a quick horseback

analysis of this here, which has diverted my attention -- we have to hand this to the public officials.

MS. SINGH: If the members are in agreeance, we can defer discussions of the public hearing in the first 15 minutes so long as the public doesn't have any objection to that. In lieu of that, we can simply have the public hearing last a little bit longer. That's basically what we can do.

UNIDENTIFIED SPEAKER: Excuse me. Can the public object?

CHAIRMAN ENTHOVEN: Yes, you may object.

UNIDENTIFIED SPEAKER: Then I'm the public, and I object.

CHAIRMAN ENTHOVEN: To what?

UNIDENTIFIED SPEAKER: Pushing the presentation 15 minutes into the public time.

MS. O'SULLIVAN: Then we'll go 15 minutes longer in the public's time.

MR. KARPF: We will have wasted all our time if we don't decide in a couple minutes.

CHAIRMAN ENTHOVEN: We'll extend the time of the public hearing by 15 minutes.

MR. KERR: Can we ask the public to take a vote?

CHAIRMAN ENTHOVEN: Would the general public be satisfied if we extend the hearing another 15 minutes?

THE GENERAL PUBLIC: Yes.

CHAIRMAN ENTHOVEN: Okay. I just have to

make some kind of ruling here. We'll start at 2:00 o'clock, and we'll extend the hearing for another 15 minutes.

(Whereupon a luncheon recess was taken.)

CHAIRMAN ENTHOVEN: The meeting will come to order. The task force is again in session. We will begin be spending 15 minutes discussing the survey that we're working on designing. This is an opportunity for Dr. Shauffler to present to the task force and for the task force to ask questions.

I will decisively cut this off in 15 minutes. But I just want to say a few things to the general public who are here to speak. The first one is we have speaker identification cards back there on the table. We request everyone to fill it out and to make it available to Alice Singh, the lady in the red jacket who's walking in that direction.

We want to have them when we begin the public comment in order that we can plan -- you know, if we have 100 people and 100 minutes, then we'll have to ask you to speak for a minute. If we have 50 people and 100 minutes, then we'll do it for two minutes, et cetera. In order to plan our progress, we do need that information, so please fill out your cards.

Next, I may come back to this again, I want to say our particular interest in this task force is in developing insights and understandings about how we can

make recommendations that will improve the system. So our interest is in general system improvement and how that might be done, not in specific episodes.

This is not a forum for pursuing individual disputes. We know that there are disagreements, bad things have happened between health care providers and health plans, but this is not the forum to try to resolve them. If you have had a problem and believe that it's illustrative of a systems problem and want to talk to us about how you think things can work better, we are very interested in that.

So with that, now that it's 2:02, we'll ask Dr. Shauffler to begin.

DR. SHAUFFLER: Thank you. I've been asked today to briefly describe to you, the task force, decisions to go ahead and implement a consumer survey to look at Californians' experiences in health plans in California, managed care and non-managed care, and I'd like to just -- there's a handout in your packet, and I'd like to run through it briefly with you, and then if -- I hope there will be time for a few questions.

In terms of the goal of this survey, No. 1, I think one of the major goals is to conduct a statistically valid survey of all Californians and their experiences. The task force is certainly collecting anecdotal information through the public hearings, but I think it's very difficult from that kind of information or from focus group information to be able to say with any

certainty what the prevalence of those problems is in the population.

So I think it's important for us to be able to document scientifically the kinds of experiences people are having and the extent to which they're having them. So the second goal is to assess the prevalence of the walls or the barriers that consumers confront and the problems they experience both in trying to use the health care system and in actually using the health care system. We want to be able to learn what the characteristics are of health plans that are associated with these barriers and problems so that we know where to target solutions.

We want to be able to assess the characteristics of the consumers and patients who are experiencing those barriers and problems, again, so we know who -- which population are experiencing problems and where we can make recommendations to improve and reduce those barriers and resolve those problems.

Next, we think it's very important as we heard earlier this morning to assess the special barriers and problems based by persons who are frequent users of the system or of people who are directly responsible for managing the care of the immediate family member who is a frequent user of the system.

We also want to assess consumer experiences in trying to overcome barriers on their own and the extent to which they've been able to resolve their problems in the existing grievance procedures of the health plans in

the state you've set up.

And then finally, our end goal is to be able to provide this task force with a comprehensive understanding of the issues that are most important to Californians regarding their health plans and the health care system which the task force can use in developing recommendations for improving access in the future.

In terms of the survey development process, I have been consulting, as has Hattie Skubik, which I have been work closely with on this project, with two different groups of experts. There are a number of individuals on the task force who have indicated their desire, and I understand there may be more, to be involved in reviewing the drafts of the survey and in talking with me about the issues and concerns that they want to make sure are addressed in the survey.

And then we've also identified a national technical advisory group, who I've also been consulting with to get materials, existing survey documents, focus group results, and just their sense of what the key issues are for us to address in this extraordinary opportunity to look at the entire population's experience.

Secondly, I have gone with my staff through an extensive review of existing consumer surveys, focus group results, and the task force public hearing transcripts to try to pull out from existing surveys questions that have already been validated and that we know are reliable so that we can build on existing survey

instruments to the extent possible, but also to assess what's missing from those instruments and what would be important for us to add in the areas of new knowledge where we can really make a contribution here in California.

So I've listed the materials that we've identified as being the most relevant, and those include several surveys that were designed by Bob London at the Harvard School of Public Health; the consumer assessment of health plans, which was the work of the Picker Institute, which you heard mentioned this morning and funded by AHCPR; the California Behavioral Risk Factor Survey, which I used this morning in my other presentation where we've added additional questions concerning managed care.

From the transcripts from this task force's hearings and the California Health Decisions Focus Group Research that Ellen Severoni made available, I was able to find many additional issues that didn't exist in any other survey that would be important for us to include, and I thank her for that.

The Kaiser Family Foundation, Harvard Survey, the L.A. Times Survey of health care in California, and the PBGH CalPERS Health Plan Value Check. Actually, we'll be pulling questions from a majority of those documents. My recommendation in terms of the core instrument, however, is to use the consumer assessment of health plans developed by Picker and funded by AHCPR.

This instrument was developed by a consortium of researchers, public medical schools, the RAND Corporation, Research Triangle Institute in Atlanta. And it was developed through extensive focus group interviews on both frequent and non-frequent users and Medicaid and Medicare beneficiaries. It was also extensively tested cognitively to make sure that respondents understood exactly what the question was asking and what was meant by the question.

I think its greatest advantage, however, is it asks very specific substantive questions about what the health plan or the primary care or nurse or doctor or the specialist did or did not do or say or recommend or -- it's very concrete in gathering information unlike most satisfaction surveys, which just ask about broad scales in terms of their level of satisfaction, which really don't provide us with actionable information. And what's so nice about the CAHP is it does provide data that's directly actionable and policy relevant.

And it asks not only about experiences in using your health plan, but also asks about attempts to use the plan or the health care system that might have failed so it looks at both people who have tried to use the system as well as people who have actually used the system.

In your handout, there's a very quick analysis of the advantages and disadvantages of the CAHP. And I think the CAHP's core does a great job of capturing

experiences of primary care, specialist care, hospitalization, and home care. But there are a number of issues that it doesn't adequately address, and it will be added to the survey that we conduct here in California.

In particular it does not address experience with emergency room use, preventive care, or the issue of hospital discharge and length of stay. And those will be important to add. It does ask a series of questions about consumer grievances, but it doesn't directly address the issue of -- I mean customer service, but it doesn't directly address the issue of grievances or their resolution, knowledge of the DOC as the state HMO regulator or DOC member for grievances.

CAHPs does not address the question of consumer knowledge about provider incentives and payments and their experience and beliefs about how those affect referrals and the care that's provided to them. It also doesn't address the issue of having to change physicians, either in joining a new plan or when a physician is dropped from their plan and the impact that that has on their care.

And it doesn't really address the issue of choice, which is very important, and we want to be able to look at choice of health plans, the number of plans they had to chose from, the types of plans they had to choose from, their choice of doctors, their choice of hospitals, and their choice of medical groups.

CAHPs also doesn't address the issue of how

well consumers understand how to use their health plan and the quality and adequacy of the communication from the plan about how to use it. It also doesn't address respondent attitudes about the role of state government in trying to address consumer problems with managed care. I think it's important for us to get some public opinions on that as well. It also does not address the issue of quality of care or value as Arnold Stein was talking about in a previous hearing, and we are going to be adding some questions on that.

We also want to ask consumers about their general impressions or attitudes about managed care and HMOs because there's some research that suggest that expectations may largely influence their experience.

And finally, it doesn't ask questions about the adequacy of the covered benefits that they have provided by their plan or the financial impact of cost sharing through their plan. And my intent is to add content that addresses all of these issues to the CAHPs instrument.

In terms of the survey method, the survey itself will be conducted by the Field Research Corporation in San Francisco. They have a computer assisted telephone interview system set up there. It will be a 25-minute interview. The sample will be selected using random digit dialing and will sample over 1600 insured Californians 18 years and older and will sample an additional 500 insured Californians 18 years and older who are frequent users of

the system and are directly responsible for managing their care or are directly responsible for managing the care of an immediate family member who's a frequent user.

We're also considering sampling the Medi-Cal population, but funding for this piece has not been fully secured. In terms of the time line here, we're on a very, very quick time line, so I ask those of you who have volunteered and are interested in being involved in this to realize that we're going to be asking for very quick turn around in terms of your response to the drafts.

The first draft will be made available to Hattie Skubik at the task force next Thursday, and the second draft will be available two weeks later on August 15, and the final draft is one week later on August 22. So I honestly do want your input, but I do need you to be very timely in your response if I'm going to incorporate it.

The completed survey questionnaire goes to the field research to begin conducting their tests to make sure that, you know -- again, they do pretesting to make sure that the instrument flows well; that there are no problems with the questions; that the length of the survey is what we anticipated it to be. And they in a very short time period will produce the top line marginals, which will show us the major percentages for each of the questions, responses to each of the questions by September 25, and complete cross tabs looking at the relationships between different variables in the survey by October 15,

hopefully in time to be able to include them in the development of recommendations to the governor.

CHAIRMAN ENTHOVEN: Thank you. Hattie, do you have anything to add about the process by which members can make input? We have some members who are tied into this by process, but if others are interested, do we want to, like, fax it out to everybody? Or what do you think?

MS. SKUBIK: I think that's something that the task force should discuss. It's a highly technical process developing -- developing a questionnaire for a survey. And while we can share the document broadly, and people can give comments on changes that they might recommend, we need to recognize that you can't simply worksmith questions without really throwing off the survey instrument.

As Dr. Shauffler said, we're planning to use a base of the survey that is approximately -- about 70 percent of the survey we're thinking will be coming from an instrument that we have from the Picker Institute. We have it electronically already. It's been developed over the last decade through Harvard, RAND, and --

DR. SHAUFFLER: RTI.

MS. SKUBIK: -- and the Research Triangle.

MS. BOWNE: What purpose was it developed?

MS. SKUBIK: For exactly what we're looking at.

DR. SHAUFFLER: CAHP stands for Consumer

Assessment of Health Plans.

MS. SKUBIK: It's been funded by Commonwealth Fund and also the agency for Health Care Policy and Research and the United States government to get at exactly what experience people are having in the receipt of health care. I think when you see that survey instrument for those of you who are interested in being involved in the process, you'll find it's a very relevant instrument.

CHAIRMAN ENTHOVEN: Dr. Northway --

DR. SHAUFFLER: What I'd like to ask, I've gotten input as you can see from the two groups, I've consulted with a lot of people. And my concern is that we only have a 25-minute interview. So the survey is going to be restricted in terms of the number of questions that we can ask. The first draft will probably have more questions than we can possibly include in an effort to be responsive and as comprehensive as possible in the first round. But what I will need people's help with, frankly, is in indicating what they think is most important to include. And to the extent that you want to add new content, to give me guidance in what you'd like to take out.

CHAIRMAN ENTHOVEN: Dr. Northway.

DR. NORTHWAY: I'm sorry. I didn't hear what you said. Just in the end when you were talking about the survey sample. You mentioned you weren't going to do Medicaid --

DR. SHAUFFLER: Medi-cal recipients will be included as part the random sample of 1600 insured Californians, but the number of Medi-Cal recipients that we will find in that pool will not being large enough for us to say anything with confidence about that population. And so if we want to be able to do that, we're going to need to fund a separate sample similar to the funding that we got from the California Health Care Foundation to help fund the sample for the frequent users.

CHAIRMAN ENTHOVEN: And we have been chasing extra money to fund that.

DR. SHAUFFLER: Yes, I mentioned that.

CHAIRMAN ENTHOVEN: Let's not get into an extensive discussion on that point. I just assure you a lot of efforts have been made, myself included, to track down the money, best efforts. If somebody has a good idea of another source we don't know about, we encourage you to let us know.

Maryann.

MS. O'SULLIVAN: Can you tell me what would be the pros and cons of changing things that we spent more time talking to people about who either encountered barriers or were frequent users? We've got 25 minutes. And it seems to me that the first -- within ten minutes, one ought to be able to find out whether the person you're talking to has encountered a barrier or was a frequent user. And if they weren't, why not move on and spend the time and money talking to people who have had the

problems.

DR. SHAUFFLER: Right. I think the difficulty, if you look at the CAHP survey, there are in fact about a core of about 30 or more questions that ask about different areas where they might have had a problem. And so it's not something you -- unless you just want to just ask a broad blanket problem. Have you ever had a problem? But that's not the way the CAHP is designed.

If we want to use the CAHP as the core, it asks very specifically about problems within each of the care settings with mental health services, pharmaceuticals, communication, with transportation. I mean, it gets on a broad range of things that if you ask whether they had a problem in a blanket way, they might not even think of that.

MS. O'SULLIVAN: Once you get past that broad range, doesn't CAHPs take you deeper to understand the problems?

DR. SHAUFFLER: It takes you deeper after each question. So if you say you didn't have a problem in that area, then you skip all that, then you just jump to the next one. But if you do have a problem in that area, then it takes you deeper in that area.

CHAIRMAN ENTHOVEN: What telephone number can the task force use to call you?

DR. SHAUFFLER: (510) 643-1675.

DR. NORTHWAY: Say that again.

DR. SHAUFFLER: (510) 643-1675.

CHAIRMAN ENTHOVEN: And we have constituted an expert resource group of people who particularly have to focus on this.

This will be the last question.

MR. WILLIAMS: Two quick questions. One is because the instrument is described as an assessment of health plans, does that mean you are ignoring insurance companies and the self-insured who not are not using health plans or --

DR. SHAUFFLER: No, we're not. In fact, we'll be asking people to tell us the specific name of their health plan. So we're not excluding anyone. We're only excluding people who don't have any insurance coverage.

MR. WILLIAMS: I think we have a semantic problem, because an insurance company is not a health plan.

MS. SHAUFFLER: The way the question was asked is: Do you have any insurance coverage?

MR. WILLIAMS: When you say it's a survey of health plans, we're being imprecise in our use of language.

CHAIRMAN ENTHOVEN: We have an ambiguity of terminology. Some people use the term to mean any health care arrangement. Other people take it to mean HMOs or PPOs.

DR. SHAUFFLER: California is unique in calling HMOs health plans. Nowhere else in the country

are those two terms equated.

DR. SHAUFFLER: Thank you. Second point is, it is really the nature of the instrument to the extent in which it needs to take into account the delivery system, instruct that it count the delivery system here in California.

DR. SHAUFFLER: Yes. We are adding a number of questions that will try to take that into account, and I would welcome any additional suggestions that you have on that.

MR. WILLIAMS: And the final point is really sample size. We conduct -- our organization -- essentially all kinds of surveys like this. It seems like it's a pretty small sample. We would normally do a larger sample ourselves, looking at all health plans, all citizens in the state. I think it's a pretty small sample.

CHAIRMAN ENTHOVEN: Thank you. I'm afraid I'm going to have to cut off the questions now. You have Dr. Shauffler's phone number. In the interest of respecting the public's --

MR. CHRISTIE: I have a letter I'd like to submit to you.

CHAIRMAN ENTHOVEN: On the record. Be sure that Dr. Shauffler gets a copy also.

(Whereupon the proceedings were adjourned at 2:15 p.m.)

STATE OF CALIFORNIA)
) ss.
COUNTY OF SACRAMENTO)

I, SERENA WONG, RPR, CSR NO. 10250, a Certified Shorthand Reporter in and for the State of California, do hereby certify;

That said proceeding was taken down by me in shorthand at the time and place named therein and was thereafter reduced to typewriting under my supervision;

That this transcript contains a full, true, and correct report of the proceedings which took place at the time and place set forth in the caption hereto as shown by my original stenographic notes.

I further certify that I have no interest in the event of the action.

EXECUTED this 29th day of July 1997.

SERENA WONG, RPR, CSR NO. 10250

STATE OF CALIFORNIA

MANAGED HEALTH CARE IMPROVEMENT TASK FORCE

PUBLIC HEARING

2:15 P.M.

Saturday, July 26, 1997

California Chamber of Commerce Building

1201 K Street

12th Floor, California Room

Sacramento, California 95814

REPORTED BY:
Serena Wong
CSR No. 10250, RPR
Our File No. 38034

APPEARANCES:

Dr. Alain Enthoven, Chairman

Dr. Philip Romero, Executive Director

Alice Singh, Deputy Director

Hattie Skubik

Bernard Alpert, M.D.
Rebecca L. Bowne
Donna H. Conom, M.D.
Barbara L. Decker
Harry Christie
Honorable Martin Gallegos
Bradley Gilbert, M.D.
Diane Griffiths
William Hauck
Mark Hiepler
Michael Karpf, M.D.
Clark E. Kerr
J.D. Northway, M.D.
Maryann O'Sullivan
John A. Ramey
Anthony Rodgers
Dr. Helen Rodriguez-Trias
Ellen B. Severoni
Bruce W. Spurlock M.D.
Ronald A. Williams
Allan S. Zaremberg
Steven R. Zatkin
Kim Belshe'
Marjorie Berte

SACRAMENTO, CALIFORNIA; SATURDAY, JULY 26, 1997

2:15 P.M.

CHAIRMAN ENTHOVEN: The hearing is now open to the general public. Let me just restate as I did moments ago, please be sure that you have a speaker card up here so that if you want us to know who are. And we will be taking them in the order that we receive them. We're going to start by scheduling each person to speak for five minutes, and then we will allow five minutes for questioning by the task force.

I'm going to have to be a little brutal in the interest of getting through all this. So I'll ask you, for example, if you have a lengthy prepared statement, you can file it with us. For the record, we'll read it, and if you just hit the highlights. I think it's more effective to present if you really give us the highlights and bottom line points that you want us to take home and then interact with the task force.

And as I said before, our focus is really on systems improvement. We are aware that there are a very large number of quality access problems with the health care system. So anecdotes reinforcing that won't point us in a helpful direction. What we really need are insights into how can the system be redesigned and who might do that in order to make this all work for people. So I'll start with Kit Costello, the California Nurse's Association.

MS. COSTELLO: I actually did bring enough

copies of my testimony, if you'd like to have those passed out and add them into the record.

CHAIRMAN ENTHOVEN: Fine.

MS. COSTELLO: I really appreciate the opportunity to be here today. I'm president of the California Nurse's Association. And as I said, I've submitted my written comments for the record. But I would just like to hit some of the high points of recommendations that were making as an organization.

First of all, the questions that were used to guide the public in their comments, I obviously -- I had some disagreement with the notion that we actually operate in the health care marketplace, because many of us have to take what's offered by our employer and I'll just offer it as an example.

Kaiser nurses that work for the Kaiser system are offered for choice of health insurance a very poor indemnity plan or the Kaiser health plan. So the notion of having a marketplace is really not very operational for us. And so I'd like to focus my testimony on some categories.

Protecting patient's rights, protecting health care professionals, patient advocacy obligations, and regulating standards for safe care. One of the things that we support is legislative mandates that would create a standard of 90 percent or greater of premium revenue that would have to be spent on patient care.

And I offer an example of U.S. health care

who spends as little as 75 percent of their premiums on care, and at the same time, during their last merger paid CEO a buy-out in cash and stopped the compensation of close to 1 billion dollars. So we believe there is a relationship.

I would also like to say that we would support some sort of debate on whether risk adjusting capitation payments might encourage health plans not to shun the sick. And it would also help, we think, with the Medicare fund in terms of the overpayments that have received a lot of notoriety of late.

Also, we support full disclosure of medical information to patients. There has been a lot of gag order legislation passed recently. We think it needs to be followed up on and enforced to prevent against abuses.

We also believe that bonuses and incentive compensation arrangements do affect clinical decisions. And just about any provider will confidentially tell you that their decisions are affected by the method in which they're compensated. Therefore, we believe that there must be a complete band on any bonuses, incentives, or penalties that would have a direct or indirect affect on health care decisions.

We also favor the legislation of whistle blower protection that would prevent managed care plans and health care employers from discharging, demoting, or terminating, denying privileges to health care professionals who advocated on behalf of their patients.

We also support in the interest of the attempt to create a marketplace in health care that written criteria for denial of care be available to patients. We think it's very important that the DOC take a role in this by mandating specifically excluded benefits, treatments, et cetera, from health plans, and publishing a comparison for the public so that people could actually make decisions regarding the choice of a health plan. And we also believe included in this should be a description of the grievance procedure for the various plans.

We also support examination by a qualified health care professional before care is denied, if there is a challenge to the denial. We also believe -- and this is something that is very dear to us as nurses -- that quality hospital care and staffing levels and health facilities need to be better regulated. We've seen the effect in the last five years in managed care reimbursement reductions for hospital care, feeling shorter length of stay, shorter recovery periods for our patients.

And in turn hospitals have turned around and reduced the numbers and skill levels of staff that talk care of those patients. So what we have essentially are sicker groups of patients with reductions in staff, reductions in the skill level, and numbers of registered nurses and others caring for those patients.

I have, if anybody is interested, a report

that we have developed to support --

Is my time up?

CHAIRMAN ENTHOVEN: Yes. Thank you very much. And we will read your report. Questions from the task force? Any comments or questions? Anything else?

All right. Thank you very much.

MS. O'SULLIVAN: I have a question. On the disclosure of criteria, what would that look like? What would -- what are you envisioning a patient would see? What kind of information would a patient get?

MS. COSTELLO: For example on quality disclosure, I think it's important to understand that both health plans and hospitals maintain large sets of data that they use for their business decisions that we never see as public.

For example, if you contact with the health plan, you don't know whether the hospital in turn subcontracted hospital care for, for example, the medication error rates, what the rates are for hospital acquired infections, postoperative wound infections, medication errors, falls, bed sores. All that is kept, but we don't know it. So that type of information is available. It's just not submitted, analyzed, and presented for our review.

MS. O'SULLIVAN: Actually, referring to criteria for denial of care, though, is that different what a patient would understand in terms of what they would be apprised --

MS. COSTELLO: Well, for example, I think the issue of bone marrow transplant for late stage breast cancer, what's the criteria upon which they would deny a woman with a late stage breast cancer bone marrow transplant? I mean, if you have a family history, I would assume you would be very interested in knowing that. I know I would.

CHAIRMAN ENTHOVEN: Clark?

MR. KERR: So you would favor on having the information on infections and adverse drug events so forth from the hospital?

MS. COSTELLO: I would. Some of it has been collected, but with the understanding that the hospital's identity would remain secret. For example, the Maryland Hospital Data Information Data Set. A lot of indicators were collected.

MR. KERR: Should it be kept from the public?

MS. COSTELLO: No, I don't think it should be. I think we have a better chance of picking out a vacuum cleaner than we do a health plan that contracts with a hospital that has quality care.

CHAIRMAN ENTHOVEN: Are you comfortable that the required reporting wouldn't feed back into incentives to not report and to cover up and --

MS. COSTELLO: I think in order to guard against that, there would have to be a regulatory mandate to go in and do audits to make sure that the data was

clean.

CHAIRMAN ENTHOVEN: Mark.

MR. HIEPLER: Is there any list of the top couple things you think managed care is doing to affect nurses good, bad, or indifferent that you're experiencing just being out in the forefront?

MS. COSTELLO: I would have to say, for example, within Kaiser there is a big push to substitute lesser trained personnel at all levels for licensed personnel. I know in the advice centers now for the adult advice calls, when they come into Kaiser, it used to be a registered nurse would be the -- the gate keeper would answer the calls.

Now we have appointment clerks and medical assistants taking information, determining whether the nurse should then become involved to give advice based on symptomatic reporting of patients. I think it's backward, and we had some problems with it.

Plus a lot of time, there's a large turn around time from the point where the call is answered, a message is generated, and a nurse calls back to get more information and do a disposition. Sometimes four or five hours. So a lot of delays.

CHAIRMAN ENTHOVEN: Harry.

MR. CHRISTIE: Based on the fact that a lot of the length of stays in the hospitals are being reduced by managed care, do you feel that some form of an informed consent is required before a patient is discharged to

advise them of the potential risks of an otherwise early discharge?

MS. COSTELLO: I think that what would be helpful is -- for example, what's happening now that's fueling a lot of those early discharges is the development of clinical pathways. So you take, for example, you know, a surgical intervention. And there's a standard for length of stay that's prescribed by the clinical pathway. And there's a lot of push to fit your clinical judgment within that pathway.

But an elderly woman with chronic anemia who's diabetic is not going to recover as quickly from a hip surgery as a healthier person at the same age. There's just too much of fitting ill people into well people's standards around these length of stay protocols. It's a real problem. And teaching isn't happening, either, especially with maternal and child issues.

What we're finding is nurses are complaining about taking a lot of, for example, breast feeding phone calls on the advice lines from fresh mothers who have just been discharged. They should have been comfortable when they went home with infant feeding and care.

CHAIRMAN ENTHOVEN: Thank you very much. Our next speaker, presenter will be Jane Parish from the Breast Cancer Advocate.

MS. PARISH: Good afternoon. I'm here to put a human face on this. I don't have all the statistics. I'm a nine-year survivor of breast cancer,

and I'm a breast cancer advocate. I work on my own. I've advocated for hundreds of women for eight years. I'm right there on the trenches, on the front lines seeing how the patients are treated through their different treating physicians and their insurance companies.

I don't accept any compensation or no consideration for what I do. So I have no axe to grind or no vested interest other than the interest of the women I'm advocating for.

I had breast cancer in 1988 and was a Kaiser patient. And I became aware -- acutely aware of the shortcomings of managed care in 1988. It became apparent to me that my options of care and access to physicians were extremely restricted.

In 1988, it was very difficult to obtain updated information concerning all options of care. The information resources that were available at that time included State of California pamphlet on breast cancer, which was required by law, the American Cancer Society, and the public library.

Obviously, I didn't feel fully informed as a breast cancer patient. It became apparent to me that if women are provided information on all treatment options, they will make a fully-informed decision. Unfortunately, very few cancer patients have the option of having an advocate.

Nine years later, being 1997, breast cancer patients are still scrambling on their own to become fully

informed and still have limited access. I'm going to give you one example that I'm currently working on so it's very fresh in my mind regarding what I would call limited access. And this regards breast reconstruction after mastectomy.

In 1997, you'll have approximately 180,000 diagnosed cases of breast cancer in the United States. Of those cases, you'll have approximately 9,000 mastectomies. And of those 90,000, you'll have approximately 30,000 that will be reconstructed. That number would seem pretty low. It's obvious to me that a woman -- it would not be a woman's first choice to live a life with one breast.

Better methods of breast reconstruction are available. They have been practiced for years, but they have not been promoted to the public. Why is this? Pamphlets from the American Cancer Society where many women go to get their information after being diagnosed did not make reference to these cosmetically improved techniques. Instead techniques of breast reconstruction are typically presented that show mediocre results from outdated procedures.

Obviously it would not benefit the bottom line of managed care insurance to increase this percentage of women choosing breast and reconstruction due to cosmetic results. Furthermore, a big concern is that women fearing deformity may delay seeking early diagnosis and treatment, which is the most important component of a successful outcome.

Better methods of breast reconstruction have the potential for reducing this fear in convincing women to seek earlier rather than late treatment. This is particularly true in younger patients who are at greater risk due the aggressive nature of breast cancer.

Restricted access to health care by managed care insurance is achieved by several strategies; point of service and panel of physician restrictions force patients to seek treatment at a limited number of facilities by a limited number of physicians who are offering a limited number of option.

This is due in part to the protection of managed care insurance under ERISA. ERISA limits the liability of managed care insurers putting on the medical care. Reimbursement schemes such as capitation offer financial incentives to physicians to under treat. It is apparent that in many cases the best treatment in managed care is no treatment.

It is further apparent that legislation is required to protect the public from excesses of managed care insurers. Specifically, statutory prohibition is required for panel physicians and capitation schemes of reimbursement.

ERISA also needs to be seriously reviewed and rewritten to make managed care insurers accountable for their decisions. Isn't it remarkable that the insurance industry in general allows the insurer to make decisions concerning the restoration of their property

after sustaining an insurable loss? Don't you think that the health insurers should allow the same freedom of choices to restore the patient's health?

It has been managed care's argument that option should be restricted to, quote, protect the patient, unquote. This is a thinly veiled excuse to deny care for profit. The public has a right to demand and the government has the obligation to guarantee the same level of protection to women's health care as is currently provided for our homes and cars.

CHAIRMAN ENTHOVEN: Thank you very much. Questions from members of the task force.

MR. HIEPLER: Is there anything you see that's an impediment to patient care in the managed care HMO doctors that you're visiting?

MS. PARISH: Well, I would say the No. 1 facility -- I visited Kaiser facilities, and talking about one particular organization, I see a lot of leading of the patient, of giving one option, saying, "This is what you need to do, and this is what you need to do."

Also, their practice there for breast reconstruction -- basically, what their line is, "We don't believe you should be immediately reconstructed because of the risk of infection, and it's a lot to undergo." But actually, in reality, what it is, is that they have only one plastic surgeon, and they know that a certain number of women are going to choose not to be reconstructed after they've undergone mastectomy, undergone chemo, maybe

undergone radiation. So it does cut the number people down who would be choosing that option. I don't see that as prevalent with other health care providers.

CHAIRMAN ENTHOVEN: Barbara.

MS. DECKER: Maybe I didn't understand you exactly, but I wanted to clarify. You mentioned that the material, I think you were saying, many women seek when they have this diagnosis, frequently it comes from the American Cancer Society?

MS. PARISH: Right.

MS. DECKER: And then the material has apparently outdated information about reconstruction?

MS. PARISH: Well, I'll tell you, one week ago -- I've been working a lot on HR164, and Ash's Bill for breast reconstruction and making that a federal law for all states.

So I've done a lot of research on that. But, yes, it is outdated. I checked with them one week ago to see what their current literature had, but it's missing this particular procedure that leaves a woman basically unscarred. It's unbelievable surgery. And in his practice -- doctors do know about this, but never once have I heard this procedure mentioned in the Kaiser system, and rarely have I heard this procedure mentioned in other settings where I've been with a surgeon or plastic surgeon.

MS. DECKER: Has there been any particular source of information that is open to the public? In

other words, not your own investigation, but a broadly accessible source that you think does have good information?

MS. PARISH: Well, in the course of the past few years, with the computer's access through the internet, there is a lot of web sites out there, and there's the NCI, but a lot of -- I advocate for a lot of disadvantaged women. They don't have this access. So they go to your typical sources, which I say are the American Cancer Society, the public library. That's where they go looking. And of course, that material is not up to date. So they really have to count on their health care provider.

CHAIRMAN ENTHOVEN: Clark? Sorry. Bernard?

DR. ALPERT: For many reasons, personal and professional, I am quite sensitive to your testimony. I have a question about your advocacy.

Have you spent time in the hospitals when the patients are inpatients?

MS. PARISH: Yes, I have.

DR. ALPERT: And as such, there's been a number of different hospitals?

MS. PARISH: Yes.

DR. ALPERT: So would you give us an opinion relative to the previous testimony we just heard about nursing, staffing, and so forth, because you're there as a patient advocate, and we can kind of see and compare a number of different places.

Do you have a theme that agrees with the previous testifier or disagrees?

MS. PARISH: I agree 100 percent. I've seen it firsthand. I had a woman who was by herself. She was a Kaiser patient, Kaiser Walnutcreek. And she didn't have any family at all, no support. She was on public assistance.

And she had gone in for a lymph node dissection as well as lymphectomy under general anesthetic. She was in -- I had talked to her before about her wishes. Did she want to stay. And she said, "Yes. I have no care. I have no one home. I'd like to be able to spend the night." I knew what her wishes were. She came into recovery. She was not conscious. She was still under anesthetic, and the nurse came in and said that she had been signed out by the treating physician. And I said, "Well this woman is not conscious. What do you intend to do?"

And she said, "We can call a cab for her as soon as she's conscious enough."

And I said, "That's not her wishes."

And they said, "I'm sorry. The doctor signed her out."

So what happened was I told her, "Either you admit your patient or I don't leave." They all know who I am, and they admitted her. And I waited until she got in the bed.

But that's probably getting more common

because if you'll look at information, I think it was given to you about me, I do a lot of picketing. And I picketed Kaiser because of their policy of releasing mastectomies in one day. They got them out of there. It's like in and out under general anesthetic. So it's still going on. There are some hospitals that -- I've been in some settings that I feel were definitely superior.

CHAIRMAN ENTHOVEN: Last one. Anthony Rodgers.

MR. RODGERS: I'd like to get into one of the issues you brought up, which was the fact that information is being either omitted or not provided to the patients.

Do you think the motivation is cost or is it just that the procedures are new and taking time to get into the use by physicians and professionals?

MS. PARISH: It's cost.

MR. RODGERS: It's cost?

MS. PARISH: I don't think. I know it's cost.

MR. RODGERS: So the particular procedure you're referring to is more expensive, and therefore --

MS. PARISH: Well, it's not that it's more expensive. It's that you would have more women choosing it. When you have a woman in a setting in a plastic surgeon's office, and she's seeing horrendous pictures of breast reconstructions with scars all over, you're talking

about tram flaps that are basically moving muscle up from your stomach, six-hour procedure, high risk of infection, you're going to have a certain number of women say, "I've already undergone enough. I'm not going to do this."

But if you could see those other results of an option that's out there, you're going to have more women chose it. managed care doesn't want more women choosing reconstruction. They want to keep that number down to 30,000.

CHAIRMAN ENTHOVEN: Thank you. Our next presenter will be Loren Johnson, M.D. California Chapter of the American College of Emergency Physicians.

DR. ALPERT: While he's coming, I have a one-line answer to the question. The procedure to which she's referring has been around since the late '70s.

CHAIRMAN ENTHOVEN: Dr. Johnson.

MR. JOHNSON: Mr. Enthoven, distinguished panelists, I represent 2,000 emergency doctors here in California for the California Chapter of American College of Emergency Physicians. We're the ultimate safety net that everybody keeps referring to as the inappropriate use. You know that one. The emergency room.

If you will, that is the exact dilemma of emergency services in California under managed care, and that is the tendency to take for granite a community service system, in essence, a public service that has its roots in public service going all the way back to the inception of emergency medicine, and sort of assuming that

it's always going to be there for you, especially under the competitive business model of managed care.

Now, it is true that the Emergency Medicine Treatment Labor Act of the late '80s has created a system of mandated services by hospitals and by emergency physicians nationwide. And this is certainly a great boom to the consumer and to the public and has, to a certain extent, strengthened the safety net.

However, it's a non-funded mandate. In essence, it's mandated benefit -- a mandated service without mandated benefits. There was never link to insurance coverage. So as we saw managed care unfold in California, we saw four systems planning. We saw examples like the GNC project here in Sacramento with 150,000 covered lives suddenly having the funding redirected for the provision of intense episodic care, but not redirecting the patients.

They still came to the emergency department, and they became COBRA violations and TALMA violations in our care, wherein they were defacto of COBRA violations of over 100 fold increased enrollment rate for Medi-cal patients over and above commercial managed care patients because of shady gate keeping.

And also, the result of unfair business practices. We've seen very poor control of the -- of the Medi-Cal managed care intermediaries by the Department of Health Services to the extent that there's -- the payment performance of many of these contracting plans has been

scandalous largely because, again, it's so easy to gain the system. It's a mandatory service without mandatory benefits.

So we saw considerable infrastructure damage. We saw our backup for our specialty panelists resigning in droves. Again, something we all take for granite. Doctors cover emergency rooms; right? It's sort of quasi under the hospital requirement of COBRA and TALMA, but not necessarily if they resign from the medical staff or find ways to squeeze out of it.

So just the assumption that you can go into any emergency room and into any community in this state or in this nation and always get the care you need and particularly the specialty emergency care you need is an enormous, not necessarily valid assumption. There's infrastructure damage and all our specialists are resigning in droves.

This is what happened with the chaos of sudden thrusts of the business model on top of a community service model.

Now, we survived this, and basically survived it by going after consumer protections to link mandated benefits. We got the Ferguson Act here in California in 1995. We're going for the Carden Act nationally. The Access to Emergency Medical Services Act which would link a prudent layperson's standard for emergency utilization to insurance coverage and would require that it be provided at least to screen emergencies

and to stabilize patients who have emergencies on a nationwide basis with no prior authorization.

In other words, direct access -- not necessarily payment for non-emergencies, but direct access at least to be screened and evaluated. So this has become sort of the Holy Grail in salvation of emergency medicine in the EMS system, if you will.

Now what's gone on since then is obviously we had to reinvent ourselves to live within the business model of managed care. I want to submit we've done that. We've got written testimony that will be available for you in Los Angeles. And we have specific recommendations for how to save the public service model of health care within the business model of health care. And with that, I would invite any questions.

CHAIRMAN ENTHOVEN: Thank you very much. Brad Gilbert.

DR. GILBERT: I think you raised a very good point, which is the discontinuity between the community's desire to have trauma centers and centers capable of providing emergency care for those who need it in terms of emergency care.

But how do you suggest you deal with the juxtaposition of individuals accessing ER care when it's really not appropriate? When they would be better served by a primary care physician or an urgent care setting? I agree with you that there needs to be this safety net, but I don't agree that there should be open access that allows

emergency rooms to be used inappropriately, both from a medical care standpoint and the business standpoint.

How would you suggest some strategies to deal with that juxtaposition?

MR. JOHNSON: Well, certainly, we need better definitions for risk stratification and presentational acuity in terms of what constitutes emergency visits. And I would say that we're working intensively on that.

However, you also need to think in terms of the fact that the emergency departments of this country are in many respects an unused resource. Yes, they've been -- everybody's trying to carve out and steer away from the emergency department use because it's been high cost. No. It's high charge. Hospitals have been cost shifting onto those services.

And, in fact, we're exploring lots of models with hospitals right now to reduce the charge of unitary pricing and so forth for ambulatory -- for episodic ambulatory care. There's no reason why our unused capacity can't be put to use in a more efficient economic sense. And in fact, we're the hub of acute care in communities. We in essence network and interact with every aspect of the community service network. So we are the ultimate managed care integrator.

CHAIRMAN ENTHOVEN: Mark Hiepler.

MR. HIEPLER: I've heard a lot of discussion among emergency room physicians about the inability to get

the approval; you're trying to deal with emergency situation, and you've got to call the 800 number and so on.

Can you describe in your organization or in your own practice if that's been a problem and any remedy that you would see for that?

MR. JOHNSON: Yes. That's prior authorization, on-site authorization when the patient gets there, and that's illegal under new HCFA regulations. And I submit to you that that will go away in California in the near future, and we intend to make that promise.

In essence, every patient who presents to the emergency department will get -- will get an emergency evaluation without economic coercion and in a timely manner. And that's one our fundamental missions, is to be able to provide that service as a service to communities.

It's been a serious problem. I'd be happy to -- I think we'll be able to reflect more on that if some of our members may have an opportunity to testify in Los Angeles. Yes, we've seen surrogate gate keeping by unqualified people from outside the community that don't have a clue. I've had -- I've had an IPA here in town, in Sacramento, and I've been practicing in Sacramento for many years, instruct their members to deny authorization because the emergency room has to -- in a memo form -- because the emergency room has to take care of them anyway. And we can save a million dollars.

I've had denials of patients on spine boards

from freeway rollovers, patients with arterial bleeders in emergency departments. That will not stand and we will not submit to it.

(Applause.)

MR. HIEPLER: That is a problem, even though it's illegal.

MR. JOHNSON: It is a problem, and it's going to go away. It's the dominant market practice. We surveyed 23 out of 43 hospitals in Orange County, and they still play Mother May I for emergency services.

CHAIRMAN ENTHOVEN: Steve Zatkin, are you going to talk about the treating between the Kaiser program and the emergency physicians? Is that what you're going to ask him about?

MR. ZATKIN: No. We are supporting the same bill, but you did indicate that under current California law, those provisions are illegal -- I mean, those practices are illegal, you were referring to.

MR. JOHNSON: It's actually under federal law, and --

MR. ZATKIN: Under California law it's legal?

MR. JOHNSON: No. But it's true under federal law. And the recent HCFA regulatory practice that the practice of prior authorization and informing the patient of the denial is considered economic coercion from obtaining emergency care.

The Ferguson Act actually has a broader

standard for emergency services, but pretty much fits with this prudent layperson's standard. In essence, a common sense standard for what the consumer thinks might -- would be a possible emergency.

The dilemma, of course, if you go in -- if you go in with chest pain and come out with a diagnosis of dyspepsia and the plan denies payment for the service, then obvious the consumer needs to have his potential heart attack evaluated. And that's an emergency service. So that the dilemma is the difference between a perceived emergency and a real emergency and what gets paid for. We think that common sense perceived emergencies and their evaluation needs to be covered.

MR. ZATKIN: All right. I don't disagree. I'm just trying to clarify what the state of the law is in California now.

MR. JOHNSON: The state of the law in California is actually a little more far reaching than the prudent layperson standard, but grants exceptions to Kaiser for a specific reason that Kaiser has an excellent post-stabilization case management system called the Emergency Prospective Review System that operates statewide. That was the ostensible reason why Kaiser got the waiver on that one.

And in essence, right now we've got a bill that excludes that in contract situations, and we don't think that should be excluded. That's the Morrow Bill 682 in the current session. We want to eliminate that.

CHAIRMAN ENTHOVEN: Ellen Severoni. Last one.

MS. SEVERONI: Just one quick question. Can you get us the data that would back up what you're saying about high charge versus high cost? Because I would be really interested in that.

MR. JOHNSON: Yes, I can. There's a recent journal publication on that issue.

CHAIRMAN ENTHOVEN: Okay. Our next speaker will be Dr. Bill Weil, M.D., from Maxicare.

DR. WEIL: Thank you very much. And before you start the clock on me, I'd just like to say a personal thing. It's a pleasure to appear before Dr. Enthoven, who many of us considered the following managed care -- twenty years ago when I was in private fee-for-service practice, we considered you a certifiable nut. And now we consider you a certifiable genius. One of us has changed his point of view.

CHAIRMAN ENTHOVEN: I just want to say, my contribution wasn't managed care. It was what started years earlier. It was called managed competition, which was to lay out a framework of the rules under which they would have to compete. Rules like what Marcus Stanley described, standardized benefits, information reporting, et cetera.

We won't take that out of your time. But at least you can start the clock. The whole idea was an affirmation that -- for this market to work, there have to

be rules.

DR. NORTHWAY: You better watch out. He might change his mind.

DR. WEIL: I live by those rules. In fact, I'm here to say something nice about managed care. I know that you heard nothing but anecdotes for the last few times you've met. But I'm here to talk about what one of the world's leading experts on health care said this morning. "Does managed care suck?" It only depends on your point of view.

If you are a fee-for-service private practice physician, then you really think it does. If you are a consumer who is part of the managed care world, then there are advantages to managed care that never appear on that other side of the fee-for-service private practice. It starts with credentialing. Every physician who's part of managed care is thoroughly credentialed, something that does not occur at all in the fee-for-service and dependent side.

As a matter of fact, the Medical Board of California tells us there are probably 2,000 people practicing medicine that have no license. That would never occur to managed care where the license is updated everyday two years, where the DEA certificates are looked at, where education and Board certification are very important, where there is recredentialing, which not only reaffirms all those necessities, but looks at things that occurred in the past few years in malpractice suits,

complaints about UR, CQI complaints or member service complaints.

The second thing is utilization review. Utilization review is something that does not occur in the fee-for-service solo or non-managed care side. Utilization review makes sure that the patient gets the appropriate level of care. And one of the things that was discussed as one of the previous speakers said, nobody is discharged unless they're discharged with a discharge plan.

At least while I happen to be representing Maxicare, I am from Cedars-Sinai. I'm the medical director of Cedars-Sinai. We do not let anybody out of the hospital unless there's a follow-up plan, whether they go to ECF or home health care, so that the better plans, I'm sure, utilization review includes follow-up hospital care.

We also make sure there's not under utilization. We do that by looking at patient or doctor complaints when they think the patient is not getting what they should have, member surveys, satisfaction, family complaints, nursing staffing complaints, or a list of diagnoses called sentinel diagnoses.

These sentinel diagnoses are diagnosis for which a patient is admitted and you wonder whether they've had a problem with their out-patient care, such as a diabetic and ketoacidosis. Were they filed correctly for their blood sugars? Were they getting the appropriate

amount of insulin? Someone with cervical cancer, did they have a pap smear? These kinds of things are going to make sure there is not under utilization.

And then member services. There's no such thing in the fee-for-service private practice of member services. You don't like the doctor, you walk. But in HMOs and PPOs and in IPAs and groups, there -- since everybody is basically the same, they try and distinguish themselves by the service they render so that the patient has somewhere to go when they have a problem to complain. They can even go to the HMO and file a formal grievance. There can be binding arbitration.

But there's a whole cadre of people that try to solve the problems the patient has, which is something that is completely absent on the other side. CQI, Continuous Quality Improvement, they look at utilization, review the complaints, satisfaction surveys, they access audits to make sure that all those quality indicators are something that they can point to, especially if they're trying to attract business and to show they are rendering a high quality of care. Nobody does that in the fee-for-service independent practice.

And finally health education. Sure a lot of HMOs and groups and IPAs use it as an advertising feature, but health education is prominent everywhere, because most people want to empower the patient to be part of the team making the diagnostics and therapeutic resolutions.

And finally physician education. Take

Cedars, for instance. I have 80 primary care physicians that are interns. If they see a wart with padding, "My God, a wart. We got to refer it." There's a lot of physician education needed to make good primary care physicians out of physicians who are not trained that way.

Those are some of the things that are positive about managed care. Some of the things that I hope you will see are the checks and balances and the safeguards meaning that managed care isn't such a horrible thing after all.

I know your commission has entirely improved managed care. And I think there's plenty of room for improvement. But, you know, it ain't so bad to start with. So that was the message I was bringing to you.

CHAIRMAN ENTHOVEN: Thank you, Dr. Weil.

Questions? Dr. Alpert.

DR. ALPERT: I'm puzzled by one, your prior discussion, particularly the prideful dissertation with regard to the quality and credentialing process.

I would assume by that that you would then both encourage and welcome the most qualified providers, physicians in any area most qualified by broadly accepted means in terms of people who have risen to the heights in the field and all the procedures, had the most experience, publications, so forth and so on.

If that's the case, then why are we seeing people who fit the description I just said in term of quality being denied access to panels?

DR. WEIL: Some people are denied access to panels when the panels are too large. For instance, at Cedars, if you have -- we have like 12,000 people in the IPA with 340 doctors in the HMO panel. They're not going to make very much money in it. If a physician has five, six, seven percent of his practice that's managed care and the rest private practice, they have a tendency to treat those people differently.

So sometimes there has to be a necessary number of people who take care of a reasonable number of patients on a panel. Only when the physician has -- when at least 30 percent of his patients are managed care will his whole mode of practice be directed toward managed care. But I hate to see people treated differently, and that does happen until there's a significant number.

CHAIRMAN ENTHOVEN: Mark Hiepler.

MR. HIEPLER: Doctor, you indicated that physicians will treat managed care parents different than other -- than fee-for-service or PPO.

Did I understand that right?

DR. WEIL: Sometimes.

MR. HIEPLER: And is that because of capitated versus the fee-for-services system generally?

DR. WEIL: At Cedars, we pay our specialists fee-for-service, but we do capitate our primary care physicians. That's where a lot of complaints come. We find that our primary care physicians have a high referral rate. And I think when they have a managed care patient,

they triage.

MR. HIEPLER: So there is a concern that patients in a managed care setting, because of the financial system, can be treated differently than those in a fee-for-service?

DR. WEIL: That's why we have a very active member service department trying to prevent that, yes.

MR. HIEPLER: Does Maxicare, because of that concern -- and I think it's a very positive thing. Because of that concern, does Maxicare describe to its members how the physicians are paid?

DR. WEIL: I don't think that Maxicare tells them specifically how they're paid because many full-risk groups, like Cedars, can pay the physicians they want to so that at Cedars we capitate our primary care physicians and pay our specialists a fee-for-service. We are going to be capitating some of our specialists, which is probably a better way to do that than to get a fee-for-service.

Because of the differences that exist in the provider community, I don't think that Maxicare as an HMO could tell its members how their physicians are going to be paid. The physician groups and IPAs could.

MR. HIEPLER: So you think -- it seems as if what you said in the chronology that it is an important thing that physicians sometimes, at least in your experience, will treat you differently. Don't you think that's an important thing that patients should know then

so they themselves can police that they're are one or two physicians that might treat them differently because of the way they're paid?

DR. WEIL: Absolutely. I think you made a very wise observation, and I think it's very important that a patient know that so they know how to, quote, play the game to make sure that they get the proper care; that member service isn't available if they feel that they've been discriminated against.

CHAIRMAN ENTHOVEN: Clark Kerr.

MR. KERR: Just a quick question. So you're no longer with Maxicare. You're from Cedars; right?

DR. WEIL: We are a Maxicare provider group. That's why Peter Augden asked me to testify for Maxicare. But I am with the provider group. I am with Cedars. We have a contract with a variety of HMOs. Maxicare is just one of the ones we have contracts with.

MR. KERR: So when you talked about a number of the -- potential of managed care, do you -- when you look at your crystal ball, as a hospital person, do you see any concerns?

DR. WEIL: Yes. I certainly do. One of the concerns -- when had the I pleasure of being on your commission, we used to look at mergers and acquisitions. And it's hard to keep track without a score card anymore who the hell is who. And everybody seems to be changing to fee-for-profit organization.

Well, if you're a for-profit organization,

you have to show a profit. And I'm concerned that the money that's available for health care is going to be -- the for-profit is going to be taken off the top. And pretty soon they're going to squeeze physicians and patients so that quality of care will start to be affected.

I would think -- I would -- like, maybe your group could say that a medical loss ratio should be limited to 80, 85 percent, because there are some organizations with medical loss ratios of 69 percent. If anything is for profit, then it better show profits. It's there on the stock exchange. And that profit -- we're not the guys making the 3 to 6, 11 million dollars in salaries, which are public record of some CEOs of these organizations.

So the money is coming from someplace. I think it's terrible when a guy can get up to bat in major leagues in two games and make more money than the average physician in the United States makes. Something is wrong.

CHAIRMAN ENTHOVEN: Dr. Karpf.

DR. KARPF: We've heard a lot anecdotally both for and against managed care. There is a body of literature out there that does speak to some of the issues of outcomes under different systems of care. And also it speaks to satisfaction levels. I would assume that we could reassure the public, we will not actually take a look at that as a group in an organized fashion in a future meeting, but I think we will see there are

positives and negatives. And what we really need to do is understand how we evaluate that data and have we accumulate the future data so we can in fact see what is working and what isn't working.

CHAIRMAN ENTHOVEN: Right. Two things about that. First, in the last meeting we did a have presentation by Dr. Arthur Miller of U.C. San Francisco, Institute of Health Policy Studies of the Loft Miller Pair, that have been kind of a deans of literature reviewing in these comparison studies. And so Dr. Miller did present to us on that.

Any of the previous articles in 1994 said HMOs are as good or better. This time he's more -- well, the score looks like it's about even. There's variations on both sides. But we will continue to look at that. And of course, all the work that Clark Kerr has described on information reporting, quality monitoring is a very important part of that.

And of course, one of the things about managed care, it gives you a framework and really somebody to hold responsible who has to do the measuring and reporting.

DR. WEIL: I just want to say some articles in general show that; that care is equal regardless of work.

CHAIRMAN ENTHOVEN: Yes. Miller Loft did, right.

DR. WEIL: Thank you very much.

CHAIRMAN ENTHOVEN: Thank you. All right. Our next speaker will be Lynnie Morgan, a consumer from Concord, California.

DR. ALPERT: One thing about Dr. Miller's presentation, simply to be complete in the summary, there was a lot of discussion about internally forming, which is perversed payment incentives. I don't bring it up as a bad thing, but --

CHAIRMAN ENTHOVEN: Yeah. Just to make sure we understood, the point he was making was the lack of risk adjusted premiums; right? Which I think we're all agreeing is something -- I trust we'll be able to build a consensus for recommending.

All right. Ms. Morgan.

MS. MORGAN: Hi. I am a parent and I am a consumer, but I also am the founder and director of the Mitochondrial Disorders Foundation of America. I have sent information out to over 1,000 people in the United States and have clients here in California, so I think about this being in their benefit also.

I sent you a letter dated July 21, actually, and make reference to that letter today. But before I do that, I wanted to tell you that we all know for any organization to be a success, it has to have certain structure. And if you will kind of imagine a pyramid with the meaning -- well, we have to have needs. We've established that people have needs. We're not born to live an eternity. We are finite creatures. So health

care is a basic need that we all have.

So with that established, that means we have a need. We have to take care of those people somehow, each other somehow. So if you can imagine a pyramid with the top third of it being meaning, and the middle third of it being structured, and the bottom third being action, that's a good prescription for success, but the only thing that's missing is the care, caring part of that.

I took a Cal State Hayward course recently where the professor showed us how these things all worked together. And without the caring, you don't have -- it's not necessary for you to have -- there's no meaning for it if you don't care about something. There's no need for structure, and you won't have to have any action, because you really don't care.

And the reason that I bring that up is that in the health care system that's currently going, currently in action right now, I think what we have done is we had doctors who took an oath to care and serve the patient. And after attending last month's -- the last session of this task force, I went home and wrote down my observations and recommendations in this letter, because as I recall, that's what you asked for, observations and recommendations.

So one of the things that I would point out is that the administration must care. It must filter down to the doctors who must care. And the patients who must know that they are cared for, or the system won't work.

One of the things I'm wondering is if we remove the incentives and capitation, if those doctors will come back to caring again and the administration will be able to care.

I know that we -- you know, the incentive is something that's worked in the past few years. People are starting to grumble about that, and with good reason. For one thing, this thing that Mr. Romero gave out this morning, I think it's very interesting that he talks about job owning. And the first five things on this list really, to me, talk about how great the need is in California.

The amount of complaints that there are have risen in the last year. Why is that? Why do we have a task force? Because the need is just so great. There are a lot of anecdotal situations. But they are only anecdotal one on one, one at a time. But when you see a room full of people sharing those situations with you, when you see a governor who has to assign a task force, they become not anecdotal. They become an issue.

I think that if we look at the system, we work on incentives, removing incentives, or working incentives elsewhere, and possibly maybe focus on developing centers of excellence so that the health maintenance organizations and the fee-for-services don't have to be all-in-all to everybody. They can't afford to be all-in-all to everybody. That's one of the problems.

My daughter can't get a diagnosis because my

HMO is saying that they are specialists in that area when, in fact, they are not. So what is the problem? Our vulnerable wind up not being heard. Our vulnerable wind up not being served. And we have greater needs and a need for a task force. I would suggest that in the statistics, when we do our surveys, that the questions are relevant.

Questions like, "Are 15 minutes with your doctor adequate time to discuss your needs with him? Do you have your doctor's individual attention when he's in the room? And are you afraid to ask questions about your health care provider for fear of losing your insurance?"

I said this at the last meeting, and I'll say it again. Surveys and data is only as good as the questions that they ask. And I applaud your discussion earlier in the questions of the gal who had the question about are we really going to talk to those people on the phone. We're spending all this money on the survey. Is it really going to meet the people's needs? I don't think so.

Thank you for letting me come. And, please, if you have any questions about my letter, I'd be happy to entertain those questions.

CHAIRMAN ENTHOVEN: Thank you. Questions? All right. Thank you very much.

Our next presenter will be Maria Joelson of the California Nurse's Association. Is she here?

UNIDENTIFIED SPEAKER: She may have left.

CHAIRMAN ENTHOVEN: Okay. We exhausted her patience. The next speaker will be Gail Oheda, Latino Coalition for a Healthy California.

UNIDENTIFIED SPEAKER: She left.

CHAIRMAN ENTHOVEN: Warren Leach, speaking for himself. Cupertino.

MR. LEACH: Professor Enthoven and distinguished members of the task force, I'm a 63-year-old diabetic. I've been a diabetic about 25 years. I'm also on medication for high blood pressure. Starting in February of '96 through March of '97, I had five strokes, the second of which put me in the Stanford Hospital.

I recall that quite vividly, because I didn't know I was having a stroke, and I called the doctor, and I said, "What do I do next, and he said you better get to a hospital." So I called the wife, and I drove halfway to Stanford to Sunnyvale, and she drove beyond to Stanford ER. I got in about 6 o'clock. I never got up to the hospital part until about 2:00 in the morning.

And apparently -- it is my strong belief they were waiting for authorization from the HMO which was FHP and wanted to be darn sure I was really having a stroke. And apparently, the type of stroke I had was called Cerebellum stroke. That's why I didn't recognize it at first because it wasn't left or right hand paralysis. I subsequently testified in SP977 regarding the medical board applying to all people involved in

health care decisions.

And as I recall, all the parties there, except myself, they said "no." And when the center piece said I'll give you an exemption, they still said no. So that's where the industry is coming from. Subsequent to the strokes, I had several heart attacks. The first one in Tahoe. Second one in Reno. I went to Barton Hospital Tahoe, Saint Mary's in Reno. And I changed HMOs in January.

Health Net made a decision to fly me up by air ambulance back to the Bay Area into Stanford. So there were three ambulance charges and their ambulance charge, and of course I was in three hospital facilities. Two of them ERs. So that particular incident is probably going to run over $50,000. And I really think that some preconditioning or premanagement of my medical problem would have prevented a lot of this. There was no ultrasound Doppler X rays until I hit the Saint Mary's hospital in Reno. There was INR protimes done for blood clotting until I got to Stanford on the second stroke.

And as far as post stroke situations, I wasn't told about quad canes. I wasn't told about walkers. They stuck me in an old folks home. I got out the next morning. The old folks home by the way was cited by the state for many violations, complaints, citations, and they changed their name I noticed after I was no longer at that facility.

So what I'm saying to you is that there

should be some preconditioning or premanagement situations of people with my health problems, and also as far as post incidences, there should be some after care that wasn't given to me, and it would have maybe lessened some of these bills. So that's briefly my statement. If anybody has any questions, please ask me.

CHAIRMAN ENTHOVEN: Thank you. Questions? Okay. Thank you very much.

MS. SEVERONI: I just want to thank you. I don't know the geography up here. I asked Clark. You drove a long way, I guess, to get here today.

MR. LEACH: Yeah. I didn't drive. She drove.

MS. SEVERONI: But you came a long way. What would be the one thing you would like to see changed about the system and what -- what would make today's drive worth while?

MR. LEACH: Well, capitation payments as I mentioned in the testimony should be outlawed or made a criminal offense. To me that capitation payment is really the crux of the whole problem. And that should be diminished or modified or something. Because I understand there's one lawsuit going around here in Sacramento where the doctors were scheduling too many appointments, and there's this capitation pressure that goes on in the whole industry.

I talked to some nurses, and they said they work 12-hour shifts. And how can you take care of

patients when you're working 12-hour shifts? So there's too much pressure put on the personnel. This profit angle I think has just gotten way out of wack. And it's got to be reigned in. And I followed the industry pretty close. I've got annual reports, 10K, and all these HMOs, and I see a lot of stuff in there that's really bad.

CHAIRMAN ENTHOVEN: Mark Hiepler.

MR. HIEPLER: Sir, before your situation and complications that you encountered, did you understand in your HMO how the physicians were paid?

MR. LEACH: No.

MR. HIEPLER: Okay. Do you think that would have helped you while you were in the emergency room if you had understood some of those things to advocate better for yourself?

MR. LEACH: I have too many things in my mind quite frankly, but we were in Kaiser at one time. We left them. We went Take Care. Take Care was bought out by FHP. And FHP was merged into Pacific. So it's very difficult to keep track of these plans as they're offered to you. I can't even get health insurance because I'm a diabetic. I got health insurance through her job. And like I said, these HMOs -- it's like Pacman. They just keep moving around.

MR. HIEPLER: Did they ever tell you why it took so long to get in the emergency room?

MR. LEACH: No. They had a CT scan. I was interviewed by a lot of nurses and emergency room

physicians and personnel. Like I said, it was 6 o'clock in the evening when I got there, and I didn't get in the hospital itself until about 2:00 in the morning.

CHAIRMAN ENTHOVEN: You mean you weren't admitted out of the emergency room into the --

MR. LEACH: Right.

CHAIRMAN ENTHOVEN: Do you have any good reason to believe that was because of the HMO as opposed to just it took all those nice Stanford doctors a while to get down there and do all the tests?

MR. LEACH: Well, I kind of walked -- I should say staggered into the ER. And I got up on a gurney, and I was there all that time. People just kept coming around interviewing me. I guess there was some question, "Is this guy really having a stroke or isn't he?" I already had a previous TIA in February. As a matter of fact, there were two TIAs according to the CT. One in the right hand side of the brain, took out the left side.

CHAIRMAN ENTHOVEN: What my question was directed at was: Is this ascribable to Stanford care or to the HMO?

DR. WEIL: Stanford care is up to speed. I had insisted on going to Stanford on the first stroke.

CHAIRMAN ENTHOVEN: Dr. Karpf.

DR. KARPF: I don't want you to take this the wrong way. Somebody must be doing something right in the health care system if you've had multiple strokes,

multiple heart attacks. And being as effective as you are as a speaker, something worked right someplace.

MR. LEACH: Well, my father is 93, and my mother is 90. So it's probably in the genes.

(Applause.)

CHAIRMAN ENTHOVEN: All right. Thank you. We're going to take a ten-minute break.

(Brief recess.)

CHAIRMAN ENTHOVEN: Will the meeting please come back to order.

Our next presenter is David Blackman. Mr. David Blackman of Tower Health.

Thank you for coming Mr. Blackman.

MR. BLACKMAN: Good afternoon. My name is David Blackman, I'm vice president, chief operating officer of Tower Health. Tower Health is a Knox-Keene licensed HMO in Southern California predominately serving the Medi-cal population.

I may not look like a traditional health care executive, and I certainly don't play one on TV, but I have worked on both sides of the fence that we're discussing. I've worked for physician billing organization and hospitals as well as 15 years in the managed care HMO side.

Eight years ago, my mother faced amputation of both of her legs, and she was a member of Kaiser Permanente, and amputation was discussed. My brother, who was not an advocate of managed care, felt that she needed

to get out of the hospital, and only a fee-for-service physician would do the right thing.

After many, many phone calls, he discovered that -- what many people told him was that the best vascular surgeon that they thought was at Kaiser. And we contacted this individual, and he accepted my mother as a patient and several days later did surgery to save her legs. But the surgery was unsuccessful.

Late that evening, the doctor contacted me and said, "I'm going to try one more thing. I've been up all night trying something else." The second surgery was also unsuccessful. So we discussed amputating of the legs. The next day the doctor came in and said, "I'm not giving up. I've got one more last try, and I want your permission to go ahead. I think that she can stand the surgery." He did the surgery. The surgery was successful and both of her legs were saved by a managed care physician who cared about the patient and who had compassion and quality in the forefront of his mind.

Today she has difficulty walking but nevertheless has both of her legs. I do not believe that it is simply an issue of what works and what doesn't. What systems to fix and what doesn't. I believe that the political and budgetary and other economic forces on health care in general are the result of the changes in managed care and changes in health care.

If this committee and the public at large will -- is going to judge the managed care industry as

well as the press based on anecdotal stories, I fervently and adamantly hope that both sides of the stories are listened to. I have worked on both sides of this proverbial fence, and I have seen what I believe to be good quality care and access in the managed care industry. And with that, I'll be happen to take any questions.

CHAIRMAN ENTHOVEN: Dr. Alpert?

DR. ALPERT: Do you have any specific recommendations for us to make to the government or the state with regard to managed care?

MR. BLACKMAN: Yes, I do. I think the issue of risk adjusted premiums that have been talked about is probably the paramount issue. I really sincerely believe that. As an example, a perfect example, the state is paying the same capitation premium for individuals on AIDS and HIV in the Medi-Cal program as they do for all other Medi-Cal individuals.

I'm a licensed and certificated counselor with HIV/AIDS patient. And I know that they have greater needs than just medical. They have social and economic and environmental needs as well. And yet my company as all other Medi-Cal subcontractors are getting $70 a month to treat an AIDS patient. I think that's an example, and I think risk-adjusted premiums are not the way to go.

DR. ALPERT: I just want to make sure I understand this. So you think the biggest problem is that the HMOs are not being paid enough for taking on high risk people?

MR. BLACKMAN: No. I'm sorry. Let me clarify that. I think the biggest problem -- I think the biggest problem is that there are sometimes intangible forces, systemic forces that include political, environmental, and budgetary at the state level that are exerting influence on the managed care industry and not the systems and the capitation system that has developed due to the changes in general in health care in this country.

CHAIRMAN ENTHOVEN: Any other questions? No comments? Okay. Thank you very much, Mr. Blackman.

Our next presenter will be Wilma Krebs, California Senior Coalition. Is Ms. Krebs here?

Thank you for coming. Please sit down.

MS. KREBS: I had a very simple question earlier on. And that was the comparison of the HMOs and the PPOs in the indemnity plans in which the PPOs came off, quote, badly, I think. And my question was about the sample, whether the PPOs, for example, included the PERS PPO, PERS care and PERS choice, which are perceived to be very high quality within PERS.

CHAIRMAN ENTHOVEN: My understanding is that survey was broad-based for PPOs, you know, PPOs across the state so that PERS would have been there to the extent of its statistical weight. But I'm not really sure of that.

MS. SHAUFFLER: It's only one PPO out of 20 or so. Whether it does isn't going to overwhelm what the majority do. But everything that we collect is

confidential; so I cannot reveal any information specific to any health plan. Otherwise, the health plans wouldn't respond to my survey.

CHAIRMAN ENTHOVEN: You raise an important point. Don't go away yet. Let's just carry this on for a minute. You put your finger on an important point, which I think we ought to draw out here, and that is that shot is called by the employer. So we're talking about the different coverage levels and, you know, let's say our mammograms covered this, that, and the other thing.

And so you ask about PERS. Well, PERS is the purchaser, and they can decide what to include in their coverage contract as they think best. So we shouldn't think of PPOs as freeflowing entities out there that are doing things on their own. The employer or the purchaser is calling the tune, and they're just dancing to that tune. I think what it reflects is that there are some employers who go for much less expensive coverage.

MS. KREBS: Thank you.

CHAIRMAN ENTHOVEN: Next. William Powers, Congress of California Seniors.

Mr. Powers.

MR. POWERS: Good afternoon. My name is William Powers. I'm here representing the Congress of California Seniors. We are the California arm of the National Counsel of Senior Citizens. We have an affiliate membership of over $500,000 in the state. Our advocacy is 100 percent volunteer. Adequate and universal health care

has been a major part of our agenda since our inception. the CCS was among the original sponsors of Proposition 186 to establish a single-payer health care system in California.

Unfortunately, that did not pass. We are proud to be a sponsor and supporter of the Patient Bills of Rights, which is winding it's way through the legislative process a couple blocks from here. We are strong supporters of the Patient Bill of Rights because of what we hear from our members and their concerns about the managed health care system. Most of our members are retirees, and a high percentage are in managed care.

The information provided at the hearing is on the 13 -- now, as I understand, it's 14 bills in the Patient Bill of Rights, as well as recent revelations in the media, we believe more than justifies the need for this important legislation. That is why many of the bills being are passed with bipartisan support.

We want to make it clear that the Patient Bill of Rights is a modest response to the rapid growth of the managed health care system and the problems for consumers which have resulted. These are not radical proposals, as some in the industry would have you believe, but measured responses to protect consumers and their health care needs.

Things like protecting the doctor/patient relationship, providing adequate information, protecting the free speech rights of consumers, and assuring

accountability are some of the issues that are addressed by these 14 bills. We cannot depend on the industry to please itself. Health care is as important for consumers as used cars, and we must look to government to protect our interest, even when it appears that this is not being done as effectively as we would like.

The bottom line for industry seems to be the bottom line. When the lives and the health -- when the lives and health of our members and consumers generally are at stake, that's not good enough. We are especially concerned that the health care needs of vulnerable groups such as the elderly, disabled, and low-income people may not be adequately addressed by the current system, and that your review will address this matter in your report.

Finally, I close by strongly urging that the work of this task force not be used as a pretext to prevent the current legislative reforms for the inactive. And I would hope you folks would support that position, because I don't think there's anything in the Patient Bill of Rights that's contradictory to what you folks are talking about today. Thank you very much.

(Applause.)

CHAIRMAN ENTHOVEN: Thank you. Steve Zatkin.

MR. ZATKIN: I agree with your last point about the role of this commission, but I wanted to ask a question because I'm a little puzzled. You said most of your members -- all of your members, I guess your seniors,

most of them are in managed care, but do you have -- unlike many of the folks in the commercial sector, they do have a fee-for-service option, Medicare, regular Medicare.

MR. POWERS: Many don't. Many don't. They come out of the kind of situations where they are retired Union members and they don't have options. They have to -- they have to be part of managed care systems or they're on -- they're on Medicare, and the choices that are there are governed by the cost of the systems that are there. So they --

MR. ZATKIN: It's the latter problem, because the cost-sharing would concern fee-for-service. So what is -- despite their concerns about managed care, they are still there because of the cost issue --

MR. POWERS: By the way, we're not here today to defend the fee-for-service system. We're here today, as the task force is set up to do, to talk about improvements in managed care. On one of the earlier speakers, I felt his position was diversionary, if anything.

MR. KERR: Thank you. Next speaker will be Lisa Merritt, Multicultural Health Institute.

MS. MERRITT: Hi, everybody that's left. I'm glad to see you all here, and I am very happy to be a part of this process and very honored. I am sorry that much of the task force has dissipated. I hope this is not a reflection of interest in the public, but more of everyone's busy schedules. I would like to make sure that

my comments get on the record.

First of all, I'd like to say that I am a specialist in physical medicine and rehabilitation. For those of you who don't know what that is, that is a physiatrist. There's a very small number of us in the country. We're unique in that we work within a multidisciplinary team concept. I think that it's a model that managed care can learn from in many, many ways. And that's part of what I'd like to speak to.

I have summarized ten main areas that I will be happy to submit to all members of the task force. There was very short notice that I received about this, and I have issued it to a few of the members, and I will be sending it.

The main areas I'd like to go through very quickly is the issue of access; the need for cultural competence and multicultural curriculum training; the need for research and useful data on outcomes and what we call outcomes, what types of outcomes; the need for collaboration amongst all the powers that be; the need for greater training of community health care workers and coordinators, as well as minority under served health care providers for under served populations and their inclusion in the health care plan and health care delivery; an effective plan of the 7 million or so uninsured people in California; a way to target education for an early and aggressive intervention strategy for high risk populations; the greater use of information technology,

and the greater need to bridge the gap between allopathic and complementary or traditional medical practice or spiritual medical belief systems.

I'd like to go into a little detail on each of these in the time remaining. First of all, for access, I think it should be very clear that we distinguish not just having insurance, not be assigned to a provider, because that does not relate -- reflect, you know, from my perspective in grass roots as a physician in practice. I'm speaking for my patients as having access. If that physician's office doesn't speak the language or doesn't have staff that are sensitive to their needs, that's not access. If that office is three bus rides away, there should be something in the questionnaire.

In the geographic managed care program in Sacramento, we had huge problems of people being shifted away from the doctor that knew them and their family to a clinic on a different part of town that they didn't know the bus route too. So the question that would be very useful, does your clinic have a bus stop that someone could walk from? That's very concrete information that I think would be helpful.

Do you have access to paratransit? My patient population have a lot of problems with mobility. They have to rely on whatever transportation there is for someone in a wheelchair. Paratransit has to schedule two weeks ahead of time or more in Sacramento. I don't know what that is in other places or if there's equivalent

resources.

Also, child care is a big issue in terms of access. We have people being assigned to plans where the mother has four kids and three of them are assigned to different pediatricians. So what does she do with the two other kids, because she can't take them to the doctor. This is the reality of what's happening. We have health -- we have child care in health clubs. I think that child care in a health clinic isn't too far fetched, particularly when it's an opportunity for health education.

The same thing tying into the issue of information technology. You don't need a big, fancy software program. I mean, in my office, we have information technology. You can use Microsoft Word, which all of these companies that have sophisticated computers to figure out how to negotiate and renegotiate the billing can certainly create electronic change; they can create educational profiles, and can have internet access right on site and show people who don't have that type of access, because not everyone does.

The multicultural curriculum is very, very important. Do we have to think of the demographic shift? This task force, this hearing right here is not reflective of California as it is today, and certainly not as California is going to be in the next 10, 20, 30 and 50 years.

Are we planning for right now a short

material stop gap measure, or are we looking in terms of strategic planning for an aging population, an extremely diverse population, among whom we know we have certain targeted health care problems like diabetes, hypertension, AIDS, violence, domestic violence. And are we prioritizing those health care problems with effective prevention programs.

Clearly from the data shown, just education in general about health is not being -- 3 percent or 4 percent. Just a few more things. In terms of the training and the collaboration, I had a chance to participate in a testimony in L.A. We worked four years to get that to happen in which we had at the same table at the same meeting community-based organizations, patient advocates, government agencies, legislative representatives, HMO representatives, academic institutions, and we talked about the same discussion you're having right here.

And what was interesting was everyone was really not that far apart. It's the perception. And that's what you're talking about, getting people in touch with their own perceptions and the perceptions of others and finding a place of respect to build interactions so you can build solutions.

And I think more of that needs to be part the process of not only this task force, but any health delivery system. You need to hear from all sides. Everyone needs to have a voice, because if you don't, it's

not going to be effective.

Look what's happened to geographic managed care. We need to have the patient input and we need to have the provider input into solutions on the system because some of them are very creative and not very expensive. Question?

MR. KERR: Questions? Yes.

DR. GILBERT: Thank you, Lisa, for coming. We're still here.

MS. MERRITT: I'm glad to see you.

DR. GILBERT: Couple questions. One is you've gone over a broad range of things, some of which I think are potentially amenable to market pressures. For example, in my area, they're not providers that speak Spanish in the health plan I'm responsible for, and in the other one there are. That could result in individuals making choices based on ability to have a language access. Which of the things you've talked about you think are more -- should be more regulated or organized governmentally? The regulation versus those that you think might respond to competition and market?

MS. MERRITT: Well, let me clarify the issue about competition and market. There's still a perception -- for example, in Los Angeles, the top three radio stations in terms of the population are Spanish speaking. But the price for advertising on those radio stations is only, like, $2,000 or $3,000 a minute, versus ABC, which is $7,000.

The perception is that that's not a market. So the perception still is, in many of these plans, this is not a viable market of people. And the perception -- and we have data research that there is often a very biased interaction for those patients in terms of their clinical outcomes, but they are the same ones that are going to have the highest risk and higher cost.

So I'm a little conditioned when we talking about market forces deciding that, because it still comes down from a decision-making process, and there are panels in Oakland that don't have one African-American provider. And Oakland is a 70 percent black population. You can't make that assumption.

That's why you need to have the multicultural training at all levels from the decision makers, legislators, HMO executives, the provider team, which includes the receptionist, the housekeepers, the nurses, anyone who comes in contact with the patient, and the patients on how to access that system.

So in terms of a solution, yes, I think you should have multicultural curricular training, because many people don't understand the needs of these different groups or the incredible disparities in terms of the health situations. And I think they don't understand that the issues of non-compliance, for example, can very much tie to communication problems.

If the person calls the office, and doesn't feel that they're being dealt with respectfully, they

don't go or they don't understand or they get lost, for example. In terms of what I think should be mandated, I think education --

MR. ZATKIN: Just to finish up, I agree with you on much of what you're saying. How do you make it happen?

MS. MERRITT: I think you need to have a certification process that's objective and that's verifiable. I think in terms of cultural competency, I think you need to make sure you have input from patients and patient representatives of all the different groups that are being provided to in part of the planning process.

And that's not something that's imposed on them. It's something that they are partners with. And that's part of the collaboration and partnership with the community that I'm speaking of, sharing resources.

And that even goes to why not have mentoring programs to begin to train trainers for community health care workers and community health educators? The HMOs would benefit from this to invest the money in the community and welcome them from a marketing standpoint.

And it also would improve outcomes because of improved education and prevention. So I guess I'm echoing the presentations earlier that there's not enough emphasis placed, and perhaps there needs to be some type of mandate that if they're using this money particularly, if they're managing Medicare and Medi-Cal, which are

public funds, then there should be some mandate to include in the use of those public funds effective education, as well as collaborating with existing traditional community health providers and collaborating with community educational processes.

MR. KERR: Another question.

DR. KARPF: I agree with you that we must face diversity of this state. It's a challenge and our greatest strength. I'd like to ask you your opinion. Is it more likely from your perspective that a tradition fee-for-service marketplace or a more organized marketplace, be it managed competition or some other level of organization, is more likely to be able to serve the needs of the culturally diverse populations who are particularly vulnerable populations?

MS. MERRITT: I think that it really -- I'm not making my point clear. I think the issue is the awareness of the system providing the care. I mean, historically, people of color, physicians of color have served those communities, regardless of whether there was Medi-Cal or Medicare or whatever.

What happened when there began to be public funds for that, other people started to serve those communities. So I think it's as much a matter of resources available, and I say this in all seriousness, I think it's more a matter of the opinion about these populations, because when you look at studies, for example, that compare cardiac care, even when the

insurance payment was not an issue, the type of care that was given was in complete reverse to the rate and the incidence and the severity of that disease process in those patient groups. In other words, black males did not get the aggressive care they should have gotten when they have the highest rate of incidence and mortality from cardiovascular disease.

So again, it's an education is what I'm speaking of. And I think the emphasis should be on education of whatever system, an education of the patients on how to access a system properly. Because they're used to, you just go to the doctor. Well, you end up going to the emergency room. You just deal with it until you're going to be dead.

And we have to change that mentality and get more into the preventive idea that you really do have access and people really do care about you and are going to take care of you, and how we bridge that perception from the patient side. And the perceptions from the provider's side is, well, this is a hopeless group of people. They're just too hard to deal with. They're too non-compliant. They show up late.

I mean, they're are so many things that come up that don't have to do with the health care process. It has to do with an interpersonal process. And people are often not aware of that. But it clearly is reflected in the type of care that's rendered and perceptions on either end of the scale when you look at the patients and you

look at the providers on that clinical interaction.

And one other piece I want to bring up that we didn't talk about was the whole influence of genetic identification of disease process and what it will mean in terms of long-term planning. What's going to happen when you have certain groups of patient populations that we know -- we already know historically have a predilection to these diseases, what are we doing when we know from eight that they're very likely to get diabetes or they're very likely to get cancer or both? How are they going to be figured in and be able to be covered in the future system? And what kind of mandate or responsibility should there be in the for-profit health insurance plan that really doesn't have those social obligations.

I'm asking you questions, but I'm trying to offer some solutions by saying we need to look at these things now and come up with useful strategies to deal with them. Otherwise, we will be having another task force in five years. Nobody wants to do this again.

MS. SKUBIK: Were you here for Dr. Legorreta's presentation this morning about the things they're trying to do to proactively do preventive care through sending disease management videos directly to patients? Did you hear that presentation?

DR. KARPF: I think that's a different issue. I think you're talking to an issue that systematically enables people to use a health care system and educates as opposed to a sporadic system.

MS. MERRITT: Yes.

DR. KARPF: And the reason I ask you that question is I wanted to see your bias as to whether you think a fee-for-service marketplace can actual respond to those kind of population needs, or whether in fact you need to have a more cohesive organized structure to be able to deal with those kind of issues in a way that's going to have reasonable efficiency.

MR. POWERS: Well, you know, I think it can be a combination of both. I as a practitioner see people in fee-for-service and managed care settings and for free. I got a check for $6.78. It was my 1099 from Medi-cal last year. And I hired a person to rebill on the new billing forms that they said we needed to use, because the previous billing forms were the ones they thought they were going to use, and then they changed their minds. And they still -- basically, I didn't get anything. I still had to pay that person several hundred dollars to try to do my backbilling. That's fee-for-service.

No, I don't think you couch it in those very basic terms. It's commitment. I do a lot of public speaking and education because I am committed and because of my training. And other physicians are like that who are committed. And I do a lot of education, and I could be a fee-for-service provider. It's more a matter of my own perspective on it. And I think a video is a nice idea. But what if that person doesn't speak English, or what if that person doesn't have a video machine?

I think most cultures bite a verbal human interface. A lot can be done with that. And I think training the trainer programs. One other piece that I want to emphasize is training the trainer programs. Community interface with the communities you serve, because you have these huge -- this dance, this one, that one, this one, that one. Everyone here has had probably two or three changes in their health care plan and possibly provider. So those relationships are being broken, and vulnerable populations are at risk.

I have populations right now that still e-mail me from across the country. My patients -- they're probably anywhere from 5 to 20 items long. I know them in my head like this. And for somebody else to try to take that person on their charts like this, and the time and the money it would cost that person to try to see them, you know, and to do something effective, it just doesn't make sense.

So I don't know if I'm making myself any clearer, but I will be happy to talk with any of you further. And I will be submitting a full report as well as some solutions that I have at other meetings.

MR. KERR: Thank you very much, Dr. Merritt.

(Applause.)

MS. SINGH: I just wanted to reassure our last speaker that we are transcribing the testimony that we receive today, and task force members will have access to this information.

MR. KERR: But in terms of commitment, this is the group. Our next speaker will be Dick Wexler.

UNIDENTIFIED SPEAKER: He left.

MR. KERR: He gave up. Okay. Sorry.

Sara Benjamin, as a Kaiser health plan member.

UNIDENTIFIED SPEAKER: She's here, but she passed.

DR. NORTHWAY: We've convinced her that everything is all right.

MR. KERR: Then we'll try for Betty Perry, who's from the Older Women's League.

MS. PERRY: The older women are enduring. My name is Betty Perry, and I'm the education and research coordinator for the Older Women's League of California.

At your last meeting, I arranged for a national report on managed care on older women to be delivered to you, and I think you have that. That was a national report. And today, I'm speaking more or less on local issues. And as I listened today, I heard some of you mention the value of advocates.

The Older Women's League is an advocacy organization. In the current legislative session, we are supporting the Patient Bill of Rights and particularly concerned about people being entitled to second opinions and care being -- and a problem of care being denied by health care managers instead of doctors. We think that doctors should determine the amount of stay a person

should have in the hospital after a mastectomy. And it shouldn't be an arbitrary time.

And in addition, I'd like to mention that in 1993 legislation was passed, which required doctors to provide osteoporosis testing. But many doctors and medical plans do not seem to even know about this today. We believe that managed care providers should look upon legislation as a real mandate for things that they're supposed to do. And we're going to continue to spread the word.

We feel that these -- the bills in the current session -- we hope that if they pass, we hope that the governor will sign them. And I liked Bill Power's suggestion that you not consider them in lieu of your report. But that's just kind of the beginning of things that we hope that you won't recommend. And we -- let's see.

And so my advocacy is kind of wearing out this afternoon. So with that, I will leave you. Oh, I know. The other thing I wanted to mention, we worked for breast cancer early detection, and we found that as advocates, we want to follow this legislation through, and we will be following your report through in the same theme.

(Applause.)

MR. KERR: Questions of Betty?

MS. PERRY: Remember that bone density testing.

MR. KERR: Next is Barbara Arnold. Dr. Barbara Arnold, California Association of Ophthalmologists.

MS. ARNOLD: Yes. Thank you. My colleagues have put me in the position of president elect of our state eye association, but I'm currently here as a patient advocate. I practice in the south part of Sacramento, where I'm probably the minority in my neighborhood.

About 60 percent of my patients have some form of managed care. I'd say between the many Medi's and the straight Medi-Cal and GNC patients, probably 43 percent have some relationship to the Medicaid program. And I will tell you there's no service code for seeing a patient through a translator. And I learned Spanish through my internship. There are so many people, the Mong, the Ming, the Pacific Rim, eastern Europeans, the Russians. We rely on a school age family member to translate or sometimes an employed adult child to translate over the telephone, but we do get a translation.

In an advocacy situation, I think the most important thing I want to bring up about access -- it doesn't mean you have a health plan. It means can you get to see a doctor in your neighborhood. A lot of people, walk, come by bus.

But when I found out from an elderly patient of mine who lives next door, who I hadn't seen in five years, and he said, "I just learned from these things going on in the Bee that I could disenroll from my plan

and get my straight Medi Medi back. I no longer have to spend 45 minutes and three bus rides to get to my doctor." He was so relieved that he could once again go to Medicare fee-for-service, Medi-Cal, and walk to a doctor on his block.

The broken relationships, I think, is the highest priority. I've been in my practice address, in my building for 16 years. Sometimes the patient will come back after a two or three intervals because they've changed health plans every year, and they'll tell me that they had M.R.I.'s and CTs and sought three or four referrals because under managed care, the doctor didn't really take time to listen to them, get a photocopy of their records, let alone read the copy of their records.

So they're constantly passed along like a hot potato. And had I retained that patient, I would have known that their loss of sight in that eye was extremely pre-existing for 20 years; that you don't have to spend more than a $20 office call to say, "things are okay."

And they get the multi-thousand-dollar workup because the new doctor doesn't know them. And if they did have the patient records, there's no way you can transfer the body of knowledge we know about somebody.

In addition to the body of knowledge, many times in a neighborhood office, we take care of parents, grandparents, aunts, and uncles. And we maybe know 15 people in the same family. And disease patterns often have great similarity among family members. And that's an

important body of information not to be lost.

Many people both employed and retired managed care programs deserve the option to pay a little more and get a PPO. But they'll say, "Well, my company only gives me two choices, and they're both HMOs. They will gladly take a little savings, pay a higher premium so they can do a fee-for-service style where they could chose the same doctors they've been accustomed to going to.

And then when they get a managed care doctor, they find out they have to wait maybe 2, 8, 12 weeks to see a doctor where there's many physicians at this time and throughout the state who have the capacity to see people the same day.

Someone earlier today had a question about, "Do you get to spend 15 minutes with your doctor?" I would like to say, "Do you get to talk to a physician?" Too many patients only get to see physician assistants or practicing RNs. And they're lucky if they get to see those if they've gotten through an advice nurse that's allowed them to get an appointment.

And then under some of the managed care programs for Medi-Cal, GNC, if I find a patient that's come to me, and they've got something serious like a paralyzed nerve or, say, optical nerve swelling, I'd called the referring practice back to see if I can get an M.R.I. or neurology consult because it's a special consult. I can't order those tests myself like I could under straight Medi-Cal.

But I'm told, "Well, there's not a doctor in today. Only the PA or only the nurse is seeing patients." And we have to wait until Monday or Tuesday until the practice has a physician because only the physician has the authority to order those more extensive tests.

And there's no mechanisms for keeping track of the vast number of people who pay out-of-pocket for services because they don't want to wait for a referral or spend 30 minutes on the phone trying to get a referral. They've got a job. They've got a family. They want an early morning appointment so they can be seen and get on.

So I have many patients who have their managed care plan for catastrophic coverage, but they want to pay because it's important they keep the same doctor/patient relationship. And I think the most sad thing is that patients are losing the right to choose.

(Applause.)

MR. KERR: Questions from the task force members?

Okay. Thank you very much.

MS. ARNOLD: Thank you.

MR. KERR: Have we missed anybody?

MS. PARSONS: I submitted, but I wanted to speak to it briefly. I submitted something. I also submitted a written testimony.

MR. KERR: Okay. Just come up and announce who you are.

Ms. PARSONS: I'm Dr. Margaret Parsons from

the California Dermatology Society. And many of you did receive the written testimony. I wish to address -- and I apologize for listing anecdotal and outcome. I had been told something that you wanted to hear those. And I apologize for that and just wanted to direct some specific comments. The reason I list some of those anecdotes, I think it's important in managed care to realize that very often patients have a very difficult time obtaining special referral when it is indeed important.

And I very often have patients coming in saying, "For six months I've been trying to get in here." And they've seen their primary care numerous times with expensive medications being used to treat when often a specialist can treat them more effectively. And I think it's important to consider that.

I am not here to say managed care is awful. I think managed care is mixed bag. There's a lot of good to it. Patients do have the ability to make some choices, and for many people it has been a more cost-effective means of having health care for seniors with limited incomes who aren't able to afford a secondary supplement insurance. managed care is not all bad.

I think it's also good in helping to have primary care physicians which do kind of coordinate a patient's care. I'm not here to say it's all bad and to fight for my specialty specifically, but I think it's important to emphasize that we need to allow for appropriate access for special referral to also prevent

elaborate authorization processes.

Patients with limited panels often come over an hour away to see me in my practice, and then due to the way the managed care is structured, I can't, you know, treat them that day. They have to come back another day after we've been able to retain referral, where they want copies of our notes, which, you know, you have to have dictations done, copying, and it's very elaborate. That is not cost-effective.

Patients are having to travel. People take off work in order to do that. Some are seniors who have to have one of their children take off work in order to bring them or people who have more difficult times traveling. It is an issue, and I would encourage you to look at the recommendation that you encourage people to look at appropriate special referral, and to help simplify authorization processes when someone is indeed being referred for something to be treated.

I also wanted to address briefly academic medicine, which is some of the information that I had received. You wanted me to address managed care's effect. I think it's important to look at how managed care is affecting training of our specialists. We must keep our specialists well-trained in order to continue to train specialists who will be able to treat people with the difficult, complex diseases, as well as to educate our primary care physician in basic knowledge of specialty diseases.

Dr. Lynch's report published in the archives of dermatology addresses not just dermatology, but all of medicine. And I think it is a good one and is worth reading and has a good summary of managed care's effect on academic medicine. Thank you.

MR. KERR: Thank you. Questions?

DR. GILBERT: Thank you for coming. You talked about appropriate referrals versus the process.

MS. PARSONS: Uh-huh.

DR. GILBERT: The process would theoretically be amenable to regulatory efforts. I'd like you to comment on that. But going to the first part, the appropriate referrals. I have read your examples really making the appropriate decisions referred to you prior to using multiple therapies on something that's, you know, not efficacious. Talk to me about how you think that issue can be addressed. And then secondly, if you agree around the regulatory approach to the process of referral.

MS. PARSONS: I think one of my concerns when I see someone coming in with a bag full of things tried, but are often very expense, is whether the primary care physician is someone receiving financial incentives for non-referral or whether there's restrictions on that managed care's group for regulation of referrals and how tightly are those primary physicians being regulated.

And to allow perhaps some laxity when they realize they're treating something that they don't know what it is, and they tell me, "Well, they weren't quite

sure. Try this. Try that." And to look at making sure the physicians are not restricted from referral when they are not comfortable or they clearly are not able to remedy a disease situation.

DR. GILBERT: How about the second term of the process?

MS. PARSONS: Authorization, I think there are some managed care plans. I treat patients from Medi-Cal -- different managed care groups as well as fee-for-service. Some of the managed care groups says "Here's something with this thing. Go ahead and treat it. Here it is." And one of the other groups says, "Only evaluation" when the primary care is written very clearly, you know, go ahead and treat these warts or go ahead and biopsy this obvious skin cancer. Or someone who is referred for a probable melanoma. When it's a melanoma, I have her authorization first and break what she's doing and get on the phone. I can't do that for everyone, or our patients will be sitting waiting hours while we try to process things.

MS. O'SULLIVAN: Can you talk to me about how the Medi-Cal authorization process feels different from referral process from patients who are coming to you through a private pay?

MS. PARSONS: When you say private pay, do you mean managed care or PPOs?

MS. O'SULLIVAN: Let's compare managed care. Medi-Cal managed care to private pay managed care.

MS. PARSONS: I would say some of the Medi-Cal I receive, they're just for one-consultation visits, which correlates with one of the major carriers, but yet some of the managed care groups say, "Hey, we realize this is something we're going to address. Go ahead and treat the condition."

Most of the Medi-Cal manage care programs is an evaluation. You have to have them back for further treatment. Some of them say you can treat. Again, they're very individual, and very often limited to one visit. One visits are frustrating, because when you initiate a treatment, you don't know how it works. So it's a very individual kind of thing.

So we have someone who spends her entire job getting referrals, making sure we have appropriate referrals for every single visit. And it can be very complex.

MS. O'SULLIVAN: Is Medi-Cal being way more --

MS. PARSONS: There's a variation. Some of the private pay are a little tighter, and some are more flexible. There's a spectrum in both.

MS. O'SULLIVAN: Thanks.

MR. KERR: Yes.

DR. ALPERT: I assume that you would agree that this task force made a recommendation to simplify the preauthorization process. What I'm interested in is if you have a specific recommendation to amplify that, to say

how to do that.

MS. PARSONS: I would say that when a patient is referred for a specific disease, that the specialist be allowed to carry through the full treatment of that disease, including the appropriate workup and such. One of the managed groups say up to so many dollars, you go ahead and do it. More than that, we need to know what's going on.

So there can be a guideline versus no, you have to ask for every single little thing. I think an authorization saying "we allow you to treat this disease within a spectrum of a certain amount" allows us flexibility to treat the patient appropriately.

The patient is less frustrated in being told they have to come back. And also the office is not as caught up in doing multiple amounts of paperwork, which has to be more costly not only to the practitioner but also to the managed group who is receiving the multiple pieces of paper.

DR. GILBERT: Can I just follow up on that? Two thoughts about dermatology. One is that in most cases when a PCP is referring to you it's either because he doesn't know what the diagnosis is or they thought they knew the diagnosis and the treatment didn't' work. So I would agree with you, there seems to be a vast majority of cases in dermatology that would be appropriate for referral that includes treatment. But I don't think that's true for many, many other specialty situations

where I'm trying to rule out a specific diagnosis, and then I want that patient to come back, because then I may send them instead to the neurosurgeon, I may send them to the orthopedic surgeon. I might agree with you, but not others --

MS. PARSONS: I would agree dermatology is somewhat different than other specialties. That is a caveat to specialty. In fact, two states have passed direct access legislation because we are somewhat different in the way some of our things are done.

MR. KERR: Dr. Merritt, do you want to come up to the microphone?

MS. MERRITT: I just want to make a quick comment on what she was saying. I think what you're also taking about in chronic conditions, in complex conditions, for example, I often will get a person referred for a consultation, and then what I will do is outline my full diagnostic impression and a suggested treatment plan. We do everything in-house. So as soon as I see the person, I fax the report over because I'm typing it.

They then know what the treatment plan is. And it's up to whoever decides it if they feel they want to follow through with that treatment plan as far as they can or if they need to refer back to me. So at least they get a full, kind of, look at what's going on. Most of the time, they kind of see where you're going. It's a coherent and justifiable process, and they're reasonable. They're going to go with you. What happens, if there's a

delay or playing around, you end up spending more money getting a complex and difficult thing to treat than if you go ahead and treat.

I'd like to back up with one of the comments. Dr. Susan Horne had done a pretty impressive study, I don't know if you've heard about it in other task force meetings, looking at HMOs across the country and looking at major health entities. It was about 15,000 people. It was a really big study.

And the bottom line was they found that if the physicians were allowed to do individualized and efficient care quickly in a timely manner, they actually saved money, particularly some of the more chronic and difficult conditions like asthma, et cetera.

And again, we come back to the multicultural populations, some of them, if they can go to the traditional providers and straight through, it makes more sense than to have to get to the primary doctor and not have to wait a week or two and have to go to the specialty doctor, where they might have to wait a few weeks or a few months even.

So by the time the specialist sees them, it's a much more complex situation, and it's harder to treat, and you have a worse outcome, and it's going to cost more.

And with regard to Medi-Cal, authorizations for Medi-Cal, there's a process called a Tar Process which involves these incredible forms. Now, I can talk about

Medi-Cal and Medicare all day long, but I'm not gonna.

DR. GILBERT: It's important, because the Tar for Medi-cal is the fee-for-service, not the managed care.

MS. MERRITT: I totally agree. And that's what I was going to point out; that depending on which system the person is in, the problem is even with Medicare, you still have to document -- if you have people with a chronic condition that you know is not going to change, and they're going to need a wheelchair, let's say, or whatever it is they're going to need, you still have to fill out these incredibly redundant forms, which cost time and money.

And one other solution that I would like to suggest is a universal form for disability, for authorization, for summary of the problem, and for medications, because it's the same information.

Now, my population -- for one patient, I have to do forms for state disability, forms social security, forms for Medicare, forms for the unemployment, forms for their employer, forms for the D.M.V. I mean, ten different forms literally, and each one asks the same questions.

One form, universal form, would save so much money for a lot of physician's offices and improve the efficiency with which people can be processed. And that has come up before. It's not an impossible concept. And it may not seem an important one, but in terms of

improving the flow, I can tell you, I can get rid of half a person just for form time alone.

DR. ALPERT: I can't resist. You really hit something. You said it's not hostile -- it may not seem important, but believe me it is. I'm paraphrase. And I think that that phenomenon exists a lot in the problems that we're facing. I think there are components just like the one that's just been discuss. And that's why I was hitting on preauthorization also. It's all part of the same thing.

There are problems that are not perceived by everyone looking at this, because they're often different -- there are very few of us, to be quite frank, who are in doctor/patient relationships on a daily basis. Those of us who are, and there are three of us right now at this table, realize that these things which may seem tiny are huge in impact in terms of cost, time, energy, efficiency, and doctor/patient relationship, et cetera.

And I hope that we're finally getting into sort of finding that out. And maybe we'll chew on it, and flush it out, and something will come of that component. Because it's a huge component.

MR. KERR: Thank you. Any questions? I'll take one more from the audience.

MS. MERRITT: Get the other doctor up here.

MS. ARNOLD: For the record, I'd like to exemplify the common problems with dermatology and ophthalmology. We'll have a mother take a child out of

school because they have a swollen lid, inflammatory. It's so unsightly and so deforming that you push on the outside and cause a refractory change. They want it drained. But geographic managed care won't give authorization for diagnosis. The GPs have already figured out the diagnosis, but we have to bring them back a week or two later after we get an authorization. And authorizations are passed out only once a week. So we have grandma in with glaucoma. You need a working employed person to bring grandma in, but you don't have the authorization to take the necessary optical photo, to do the visual fields.

And if there's high pressures and visual field laws, you got two out of three indicators. We can go ahead and start treatment that day. But you have to withhold treatment for several days, because it's one day at a time, very piecemeal. You can do one piece, and you can only get an authorization for one thing at a time. And there's such an efficiency if you can do it all at once.

MS. O'SULLIVAN: Do you see Medi-cal managed care patients?

MS. ARNOLDS: A lot, yes.

MS. O'SULLIVAN: How do you see that compared to your private paid managed care?

MS. ARNOLDS: Or even could I compare it to, like, straight Medi-Cal, is there really efficiency there, where as the geographic managed care, you can't do

anything without an 11 digit authorization number, and you have to wait a few days to get it by fax. Sometimes you can get it the morning after.

MS. O'SULLIVAN: How about compared to private pay managed care? Is it way more difficult?

MS. PARSONS: Well, some plans -- they're very similar. When I entered this town, I could run my office with one and a half full-time equivalents. Now it takes about four full-time equivalents. The paperwork used to get managed one day a week. Now it's a two-person five-day-a-week job, I'm not seeing more patients, but I'm paying much higher wages for the paperwork shuffle.

MS. RODRIGUEZ-TRIAS: I wanted to ask because since in the whole -- managed care is the cost in payment because of these controls, if you will, to over utilization or whatever. What's the answer? Is there possibly advice for people who have certain conditions?

MS. MERRITT: Yes. This is what I was speaking about when I was talking about targeting high risk populations. There should be some kind of fast track so people don't get caught like this and run into -- I mean, especially when there's such a serious outcome such as loss of vision, which I have seen also. And loss of function, which I have seen also.

There should be a fast track. We have a priority person. And in part, again, it is education, because who is making the decision often. The decision is being made by someone you have to spell out the diagnosis,

and that is not only infuriating at times when you're exhausted and trying to do the right things. It's very frustrating when you as a physician understand the severity of a situation, and trying not to sound like you're just trying to, you know, get your Porsche payment. You're trying to get this thing done for the patient.

And you're having to reason with a system that the way sometimes it's structured is very irrational, because you also know their goal is try to save money.

And it's a matter of prioritization and education, you know. If you have a diabetic, hypertensive patient that has classic signs and symptoms, that person needs to be fast tracked. Like the other person said, Kaiser didn't have the medical assistance. There's a problem with that. There has to be a certain quantity of the people, you know, making the decision and a system to educate so that there's a prioritization or triage, if you will, and to understand the outcome.

Going back to Susan Horne's data. If you give people what they need, go outside and institute formulas for certain patient groups because it's going to work better or they're going to be more compliant, you're going to end up having better outcomes and you're going to reduce costs in the long run.

MR. KERR: Any other questions? Rodgers.

MR. RODGERS: Based on what you're saying, what you're describing is what I call hassle factor. Hassles of getting them in for care.

Do you think the poor performing managed care plans will be weeded out in the long term? By long term, I mean next three to five years, or that there has to be legislative initiative cause, raising of the bar, consistent raising of the bar?

MS. MERRITT: I would say without legislative initiatives, I would probably move out of this country. I could go to Jamaica, and I would have better prenatal morbidity mortality rate than right now as an African-American woman if I were to have a baby in America.

There's something terribly wrong with that. And there is no incentive. And what's happening now is with vertical integration, which we're at in Sacramento, you're not even dealing just with capitation. You're dealing with an entire infrastructure that has now grown like a cancer that's just totally solidified and organized itself. And the whole impetus is leaving out the people in the process, the providers, namely the provider teams and the patient. And it's often not even based on rationality. It's based on a concept that was set forth, and it's kind of going on its own now.

And you see people shunted, and they're not looking at the whole picture. There's not enough time. Everyone is pressed for time. There's more errors being made. There's going to be more liability. But who's going to suffer in the end? The only one I care about is the patient. The patients are going to suffer.

So legislative input to say there has to be accountability, this, this, and this in terms of where the money is being spent, how much education is being made, how much community collaboration is there, how much targeting of high risk populations, what really is compliance ratio, and are you getting -- I mean, I have patients who do pay out of plan to come see me.

I have to literally write -- not only write letters, but get on the phone with their physicians in their delivery systems. I'm not even trying to yell at the -- they're paying me cash. I'm not even involved in it. And I can't even convince them to treat high blood pressure that's not being treated properly, to get the diabetics under closer control.

Diabetes in my family -- for example, all my first cousins have it, except for the last one that was just pregnant. She couldn't get into a birthing class, even though her plan advertised that they have prenatal birthing classes. She's 35. She's high risk. Her sister just had an 11-pound baby and was diabetic. And I'm saying you have to get into birthing class. They have to follow you carefully. They need to do additional tests. She was growing huge quickly, all the signs of early diabetes, and she couldn't get in to be seen any faster, get any closer attention through that system that advertised it having these things in place.

And I'm not in that system. So what I'm saying, it's a conceptual framework we're talking here.

It's beyond the hassle factor, the authorization process. And I think, you know -- I'm going to let you speak too -- I think legislatively we're going to have to look at certain standards of care. Not define quality as how long they have to wait or how long before they get an appointment with a warm body or how much they save or how much they go down in their premiums.

Quality needs to be defined by effective outcomes, amount of people who are educated, changes in health behaviors, those kind of things, which I think this survey is going to be important.

MS. PARSONS: I would address when you said the types of plans that are more onerous, I believe that word has been used, are some of the larger ones. Or the one I particularly get more frustrated with is one of the larger groups. You have to remember that the large HMOs, it's also -- it's a business driven thing, and the large employers are choosing that which is most cost effective.

So long as that HMO continues to be cheaper, that employer may continue to contract with that organization. And until there are requirements for employers to provide more than one plan, provide a PPO plan, those more tightly regulated type HMOs, regulated meaning they control cost factor and are more onerous to deal with, those HMOs I think will continue to exist.

It's a business thing not only from an HMO standpoint, but also from all of our large employers in our state. So it's not a new issue.

MR. KERR: Any other questions? Fascinating afternoon. Did we miss anybody else? I want to let you know if you would like to submit written testimony, contact one of the task force members. The next hearing is in Los Angeles, Thursday, August 7. Thank you very much for your time, especially on Saturday. And I declare this meeting closed.

(Whereupon the proceedings were adjourned at 4:46 P.M.)

STATE OF CALIFORNIA)
) ss.
COUNTY OF SACRAMENTO)

I, SERENA WONG, RPR, CSR NO. 10250, a Certified Shorthand Reporter in and for the State of California, do hereby certify;

That said proceeding was taken down by me in shorthand at the time and place named therein and was thereafter reduced to typewriting under my supervision;

That this transcript contains a full, true, and correct report of the proceedings which took place at the time and place set forth in the caption hereto as shown by my original stenographic notes.

I further certify that I have no interest in the event of the action.

EXECUTED this 29th day of July 1997.

SERENA WONG, RPR, CSR NO. 10250